STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

MAR 8 2000

Mr. Dan McCarthy
Health Care Financing Administration/CMSO
Mail Stop S2-03-08
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Mr. McCarthy:

This is the third amendment to Iowa's state plan for the Healthy And Well Kids in Iowa (HAWK-I) program. This amendment adds a third managed health care plan, John Deere Health Plan, to selected counties in Iowa. Additionally, the state plan is being amended to remove cost sharing for American Indian/Alaska Native children in accordance with the Dear State Medicaid Director letter dated October 6, 1999, and to allow a deduction for depreciation of capital assets when considering self-employment income.

If you need further information or have any questions, please call Anita Smith at 515-281-8791 or Anna Ruggle at 515-281-4186. Thank you.

Sincerely,

Jessie K. Rasmussen
Director

Enclosures: Amendment
John Deere Evidence of Coverage
Deloitte and Touche Actuarial Report on John Deere
Iowa Map

CC: Tom Lenz
Associate Regional Administrator
Division of Medicaid and State Operations
601 E. 12th St, Room 227
Kansas City, Missouri 64106

Third Amendment to the
State of Iowa Children's Health Insurance Program
Healthy And Well Kids In Iowa (HAWK-I)

Section 1. Amendment to the State Plan. The State Plan is amended and supplemented as follows:

1. **Section 4. Eligibility Standards and Methodology.** (Section 2102(b)); subsection 4.1.1 shall be deleted and the following language substituted:

4.1.1 Geographic area served by the plan: The state has been divided into six regions for the purpose of establishing plan participation. (Refer to Attachment "S") If a health plan wants to provide coverage in any county within a region, it must be provide coverage in every county within that region in which it is licensed and has a provider network established. Under HAWK-I, managed care plans can only provide services in those areas of the state in which they are licensed and in which a provider network is established.

Effective April 1,2000, three managed health care plans, Iowa Health Solutions, **Unity** Choice from Wellmark Blue Cross Blue Shield, and John Deere Health Plan are providing coverage in the following Iowa counties:

Iowa Health Solutions only:

Calhoun	Hardin	Muscatine
Clinton	Lee	story
Des Moines	Louisa	Van Buren
Hamilton	Marshall	

Unity Choice from Wellmark Blue Cross Blue Shield only:

Black Hawk	Carroll	Fayette	Jones	Shelby
Bremer	Cedar	Grundy	Madison	Washington
Butler	Clarke	Iowa	Montgomery	
Cass	Dallas	Johnson	Pottawattamie	

Iowa Health Solutions and Unity Choice:

Benton	Linn	Marion	Warren
Boone	Lucas	**Polk**	
Buchanan	Mahaska	Tama	

March 1,2000

Iowa Health Solutions and John Deere:

Clayton Dubuque Jackson

John Deere and Unity Choice:

Delaware

Iowa Health Solutions, Unity Choice, and John Deere

Scott

Wellmark Blue Cross Blue Shield Classic Blue, an indemnity plan provides coverage in the remaining 55 counties of the State.

2. **Section 4. Eligibility Standards and Methodology.** (Section 2102 (b)), subsection 4.1.3 a second paragraph will be added:

4.1.3 Income: Under HAWK-I, countable earned and gross unearned income cannot exceed 185% of the federal poverty limit for a family of the same size. Effective December 1, 1999, 20% of earned income (including self-employment income) will be exempt when determining family income for the HAWK-I program.

Income from self-employment: Under HAWK-I, income from self-employment will be the gross income minus the cost of doing business. This includes the cost of depreciation of capital assets as identified for tax purposes.

3. **Section 4. Eligibility Standards and Methodology.** (Section 2102)(b((2)), subsection 4.3, Initial Enrollment, the third paragraph will be deleted and the following substituted:

4.3 Upon receipt of a completed application, the third party administrator must determine HAWK-I eligibility within 10 working days. If it is determined the child is uninsured, that countable income in below the HAWK-I limit, and that the child otherwise qualifies, a notice of approval is sent to the family. Included with the approval notice is information about the health plans available to the family and a Plan Selection form on which the family must make their selection. If countable income exceeds 150% of the federal poverty level, the family is also required to pay a premium of $10 per month per child, not to exceed $20 per month, regardless of family size. Cost sharing is not assessed to American Indian or Alaska Native children, regardless of income. (See subsection **4.4.4)**

4. Section 4. Eligibility Standards and Methodology. (Section 2102)(b)(3)(D)), subsection 4.4.4, add to the second paragraph:

4.4.4 No premiums will apply to American Indian or Alaska Native children.

TMS CONTRACT
PROVIDES FOR COMPREHENSIVE
HEALTH CARE TO THE EXTENT HEREIN
LIMITED AND DEFINED.

It Is Issued By

JOHN DEERE HEALTH PLAN, INC.

A Corporation Certified Under The Applicable Laws
of the State of Operation.

EVIDENCE OF COVERAGE.

The Member is the person that the HAWK-I Program Administrator has enrolled. John Deere Health Plan, Inc. is referred to as "JDHP" in the rest of this Contract.

This Contract entitles the Member to receive the benefits. This Contract lists and describes them. Those benefits are subject to all of the terms and conditions of this Contract.

This Contract is executed as of the effective date confirmed by notice from the HAWK-I Program Administrator.

John Deere Health Plan, Inc.

By: _____
President

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ARTICLE I - DEFINITIONS

1.1 **Allowed Charge** means the portion of a charge for a service or for a supply that JDHP covers. One or the other of the following statements defines the Allowed Charge.

1.1.1 For a service by a Plan Provider, the Allowed Charge is the rate that JDHP has agreed to pay the Plan Provider under a contract.

1.1.2 For a service by a Non-Plan Provider due to a Medical Emergency or with a Preauthorized Referral, the Allowed Charge is the Reasonable and Customary Charge,

1.2 **Attending Physician** means a Plan Physician who is primarily responsible for the care of a Member with respect to any particular injury or illness.

1.3 **Complaint** means that a Member who is dissatisfied with JDHP has filed the written Member Complaint Form. The method for filing the Member Complaint Form is set forth in Article XIX of this Contract.

1.4 **Contract** means this evidence of coverage. It also includes any endorsements and papers which may be attached to it.

1.5 **Copayment or Coinsurance** means that amount, if any, which a Member must pay. There may be times when a service is not fully prepaid under this Contract. JDHP will waive Copayments or Coinsurance if there is a state law which requires such a waiver.

1.6 **Grievance** means a Complaint which the Member has reported to JDHP and which remains unresolved to the satisfaction of the Member. The method for filing a Grievance for formal proceedings is set forth in Article XIX of this Contract.

1.7 **Home Care Services** means the care received when a Member is confined to his or her home. Such care must be related to a recuperative or treatable illness or injury. The Attending Physician must provide a Preauthorized Referral for Home Care Services. A Home Health Agency must provide the Home Care Services.

1.8 **Home Health Agency** means a public or private agency that specializes in providing nursing services to a Member at home. It must have a license to operate as a Home Health Agency under state or local laws that apply. It must have a contractual relationship with JDHP as a Home Health Agency.

1.9 **Hospital Services** means bed and board of the character classed as semiprivate or intensive care and all other services customarily furnished in a Plan Hospital or Nursing Facility.

1.10 **Medical Emergency** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.10.1 placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or

1.10.2 serious impairment of bodily functions; or

1.10.3 serious dysfunction of any bodily organ or part.

1.11 **Medicare Act means** Title XVIII of the Social Security Act. It may be and has been amended from time to time.

1.12 **Member** means a child whom the Program Administrator enrolled in the HAWK-I program. Such a child is eligible to receive the services that this Contract provides.

1.13 **Non-Plan Provider** means any provider, including but not limited to, a physician, a hospital or an extended care facility that has not been designated as a Plan Provider by JDHP.

1.14 **Nursing Facility** means an extended care facility which JDHP has designated as a Nursing Facility. Applicable state law must accredit it, or the Medicare Act must recognize and consider it eligible for payment.

1.15 **Plan Hospital** means an acute care general hospital which JDHP has designated as a Plan Hospital.

1.16 **Plan Physician** means any licensed physician whom JDHP has designated as a Plan Physician. JDHP will designate the services that a Member may receive fiom such a physician without a Preauthorized Referral.

1.17 **Plan Provider** means any provider, including but not limited to, a physician, a hospital or an extended care facility that JDHP has designated as a Plan Provider.

1.18 **Preauthorized Referral** means a written authorization that a Plan Physician has provided for medically necessary covered services fiom a Non-Plan Provider. Payment will be made only if the referral is obtained fiom a Plan Physician and approved by the medical director of JDHP prior to the time the services are provided, except when Emergency Services are required.

1.19 **Primary Care Physician** means a Plan Physician chosen by the Member fiom the list of Primary Care Physicians identified in writing by JDHP. Further details about Primary Care Physicians are set forth in Article XIII, sections 13.1 and 13.6.

1.20 **Reasonable and Customary** means the portion of any charge that is within the amount charged for similar services and supplies in the area where the charge is made. JDHP determines what is a "Reasonable and Customary" charge. It does so by using data fiom the Health Insurance Association of America (HIAA). HIAA collects fee information based on zip codes fiom insurance companies. Those companies cover more than 95 million individuals. JDHP bases reimbursement on the 80th percentile of HIAA profiles.

1.21 **Service Area** means the geographical area encompassing the counties listed in Attachment B to this Contract.

ARTICLE II – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

2.1 The State of Iowa's Third Party Administrator will complete all eligibility, enrollment, and termination activities for the HAWK-I Program. The Third Party Administrator will be called "Program Administrator" in the rest of this Contract. Attachment A to this Contract contains the name, address, and telephone number of the current Program Administrator. If there are questions about a child's eligibility, the effective date of his or her coverage or premiums, or to report a change in circumstances (such as a change of address), contact the Program Administrator.

ARTICLE III - SCHEDULE OF MEDICAL BENEFITS

3.1 The benefits that are listed in this Evidence of Coverage will be paid only when the services are provided by a Plan Physician or arranged or approved by a Plan Physician with a Plan Provider except in the event of a Medical Emergency or with a Preauthorized Referral. The medical director of JDHP will evaluate all services, whether they are directly provided or are authorized by a Plan Physician. Payment will not be made for any service provided to a Member unless such service is listed and described below.

3.2 Benefits will be paid only for a service or a treatment, hospital, medical or otherwise, which is medically necessary. To be medically necessary, the service or the treatment must meet the following criteria as determined by the Attending Physician and be authorized in advance and on a timely basis by the medical director of JDHP:

3.2.1 The service or the treatment must be consistent with generally accepted principles of medical practice for the diagnosis and treatment of the Member's medical condition; and

3.2.2 The service or the treatment must be performed in the most cost effective way in terms of the treatment, the method, the setting, the frequency and the intensity, taking into consideration the Member's medical condition.

3.3 The following schedule of benefits has a **lifetime maximum benefit of $1,000,000.00.** This maximum applies only to the schedule of the medical benefits that are described in this Article. The benefits which may be paid for additional coverages, such as dental, vision, and prescription drug, which are listed and described in separate Articles within this Evidence of Coverage and which have separate benefit maximums, are not included in the lifetime maximum benefit of $1,000,000.00.

Hospital Inpatient Services

1, Room & Board	100% of Allowed Charge.
2. Miscellaneous	100% of Allowed Charge.
Outpatient Facility or Surgi-Center	100% of Allowed Charge.
Emergency Room	100% of Allowed Charge made by the facility for Emergency Services provided in response to a Medical Emergency. There will be a $25 Copayment per visit applied to Allowed Charge made by the facility for the treatment of any condition which does not meet the definition of Medical Emergency. **JDHP does** not **cover follow-up care obtained in the emergency room.**
Nursing Facility	100% of Allowed Charge. There will be a maximum of 100 days per calendar year.

Home Health Care	100% of Allowed Charge. This type of care must be approved in advance by JDHP.
Ambulance	100% of Allowed Charge in the event of a Medical Emergency.
Outpatient Physical/Occupational/ Speech Therapy Services	100% of Allowed Charge. There will be a maximum of 60 outpatient treatment days for each disability.
Prosthetic Devices	100% of Allowed Charge.
Durable Medical Equipment	100% of Allowed Charge.
Chiropractic	100% of Allowed Charge with Preauthorized Referral
Hospice Care	100% of Allowed Charge with Preauthorized Referral
Organ Transplants	
Physician Medical Services	See under "Physician Medical Services," which follows below.
Physician Surgical Services	See under "Physician Surgical Services," which follows below.
Hospital Services	
1. Room and Board	See under "Hospital Inpatient Services," which is on the preceding page.
2. Miscellaneous	See under "Hospital Inpatient Services," which is on the preceding page.
Physician Medical Services	
1. Routine Physical Examinations which include well-child care	100% of Allowed Charge.

2. Office Visits	100% of Allowed Charge.
3. Inpatient Hospital Visits and Consultations	100% of Allowed Charge.
4. Outpatient Consultations	100% of Allowed Charge.
5. Home Visits or Nursing Facility Visits	100% of Allowed Charge.
6. Allergy Testing	100% of Allowed Charge.
7. Allergy Injections	100% of Allowed Charge.
8. Immunizations	100% of Allowed Charge.
9. Injections	100% of Allowed Charge.
10. X-ray and Laboratory Services	
For the treatment of an illness or an injury	100% of Allowed Charge.
As a part of a preventive examination	100% of Allowed Charge.
11, Anesthesia	100% of Allowed Charge.
12. Radiation Therapy and Chemotherapy	100% of Allowed Charge.
13. Physician Emergency Room Services	100% of Allowed Charge.
Physician Surgical Services	
1. Office	100% of Allowed Charge.
2. Outpatient	100% of **Allowed** Charge.

3. Inpatient	100% of Allowed Charge.

X-Ray Imaging and Laboratory Services

1. Hospital (Inpatient or Outpatient)

For the treatment of an illness or an injury	100% of Allowed Charge.
As a part of a preventive examination	100% of Allowed Charge.

2. Office

For the treatment of an illness or an injury	100% of Allowed Charge.
As a part of a preventive examination	100% of Allowed Charge.

3. Radiation Therapy and Chemotherapy	100% of Allowed Charge.

4. Low Dose Mammography*

For the treatment of an illness or an injury	100% of Allowed Charge.
As a part of a preventive examination	100% of Allowed Charge.

*"Low dose mammography" means an x-ray examination of the breast using equipment dedicated specifically for mammography. This includes the x-ray tube, the filter, the compression device, and the image receptor. The radiation exposure will deliver less than 1 rad per breast for 2 views of an average size breast.

Maternity Services

1. Physician Surgical Services	100% of Allowed Charge.

2. Inpatient Hospital Services	
Room & Board	100% of Allowed Charge.
Miscellaneous	100% of Allowed Charge.
Inpatient Well Newborn Services	
1. Physician Inpatient Medical Services	100% of Allowed Charge.
2. Physician Inpatient Surgical Services	100% of Allowed Charge.
3. Inpatient Hospital Services	100% of Allowed Charge.
Mental Health Services	**A selected treatment program provider must authorize all services in advance.**
1. Inpatient Facility	100% of Allowed Charge. There will be a maximum of 30 inpatient days per calendar year.
2. Outpatient Facility	100% of Allowed Charge. There will be a maximum of 20 outpatient days per calendar year.
3. Inpatient Physician	100% of Allowed Charge. There will be a maximum of 30 inpatient visits per calendar year.
4. Outpatient Physician	100% of Allowed Charge. There will be a maximum of 20 outpatient visits per calendar year.
5. Office	100% of Allowed Charge. There will be a maximum of 20 office visits per calendar year.

Psychological Testing	There is a **$75** per calendar year maximum.
Substance Abuse Services	A selected treatment program provider must authorize all services in advance.
1. Inpatient Facility	100% of Allowed Charge. There will be a maximum of **30** inpatient days per calendar year.
2. Outpatient Facility	100% of Allowed Charge. There will be **a** maximum of ***20*** outpatient days per calendar year.
3. Inpatient Physician	100% of Allowed Charge. There will be a maximum of **30** inpatient visits per calendar **year.**
4. Outpatient Physician	**100%** of Allowed Charge. There will be **a** maximum of 20 outpatient visits per calendar year.
5. Office	100% of Allowed Charge. There will be a maximum 20 office visits per calendar year.

NOTE: The treatment of a medical complication which results from the abuse of or the addiction to alcohol or drugs shall not count toward any of the Substance Abuse maximums shown under this heading. The payment for medical complications will be made as for any other illness.

ARTICLE IV - HOSPITAL SERVICES AND NURSING FACILITIES

4.1 Hospital Services shall be covered, subject to the limitations in Article 111, only when a Member is admitted to **a** Plan Hospital or a Nursing Facility by a Plan Physician, except in the event of a Medical Emergency or with a Preauthorized Referral.

4.2 Hospital Services for psychiatric care, alcoholism, and chemical dependency are subject to the limitations of Articles III and VII.

4.3 Hospital Service charges in a Plan Hospital or a Nursing Facility:

4.3.1 In semiprivate accommodations, a Member shall be entitled to Hospital Services. A Plan Hospital or a Nursing Facility shall not make any charge to the Member.

4.3.2 In private accommodations, a Member shall be entitled to Hospital Services but the Member shall pay directly to the Plan Hospital or the Nursing Facility its regular charge for the private room he or she has occupied less a credit equal to its most common charge for semiprivate accommodations. However, if a Plan Physician has authorized private accommodations, the Member shall be entitled to full coverage.

4.3.3 In an intensive care unit, a Member shall be entitled to all services of the intensive care unit, including special duty nursing. The Plan Hospital shall not make any charge to the Member.

ARTICLE V - SPECIAL BENEFITS

5.1 Professional care or other services listed in this Article shall be covered, subject to the limitations in Article III, only when they have been provided by a Plan Physician or have been arranged or have been approved by a Plan Physician with a Plan Provider, except in the event of a Medical Emergency or with a Preauthorized Referral.

5.1.1 **Home Care Service - A** Member who is confined to his or her home may be entitled to the nursing services provided by a Home Health Agency when they have been authorized by a Plan Physician. Such visits shall include part-time or intermittent home health care by, or under the supervision of, a registered nurse.

5.1.2 **Ambulance Service**

5.1.2.1 For an emergency, JDHP will cover ambulance services for a Member to the nearest facility that is equipped and staffed to provide necessary services.

5.1.2.2 For a non-emergency, JDHP must approve the use of an ambulance in advance. JDHP's approval may entitle a Member to coverage for three types of ambulance use. The first type of use is for ambulance services to a hospital. The second type of use is to transport a Member between hospitals when the first hospital cannot provide the specialized care that is needed by the Member. The third type of use is to transport the Member between a hospital and a Nursing Facility.

5.1.3. Outpatient Rehabilitative Therapy – Benefits for outpatient rehabilitative therapy (which includes but is not limited to: speech therapy, physical therapy, and occupational therapy directed at improving physical functioning of the member) will be paid for a condition which is expected to result in some significant improvement within two months as determined by the Attending Physician. Occupational therapy shall not include vocational therapy, vocational rehabilitation, educational or recreational therapy.

5.1.4 Prosthetic Devices - Benefits are payable for a prosthetic device that is supplied by a Plan Provider. It must have been prescribed or arranged by a Plan Physician. Also covered are the replacements of unusable prosthetic devices. *So* are the repairs of those devices furnished on the order of a Plan Physician also covered. The supplies and the equipment which does not have any function other than in connection with the use of the prosthetic device are covered.

5.1.4.1 A "prosthetic device" means a device that meets at least one of the following requirements. It replaces all or a part of a body organ (including contiguous tissue). It replaces a diseased, a malformed, or an injured portion of the body. It replaces all or a part of the function of a permanently inoperative or a malfunctioning bodily organ or a portion of the body.

5.1.5 Durable Medical Equipment - Benefits are payable for durable medical equipment supplied by a Plan Provider. A Plan Physician must have prescribed or arranged for it to be used other than in a hospital or facility that provides nursing or rehabilitation services. Benefits will not be paid for special features or equipment requested by the Member for his or her personal comfort or convenience unless they are medically necessary.

5.1.5.1 Durable medical equipment means medical equipment that meets all of the following requirements. (1) It can withstand repeated use. (2) It is primarily and customarily used to serve a medical purpose. (3) It is prescribed to accommodate need(s) arising from illness or injury. (4) It is prescribed for use other than in a hospital or a facility that provides nursing or rehabilitation services. (5) It is owned by JDHP and on loan to the Member.

5.1.6 Organ/Tissue Transplants - In regard to organ and tissue transplants that are not otherwise excluded, JDHP provides benefits only at pre-approved facilities. Such facilities may be outside the Service Area. The Member's Plan Physician must contact JDHP in order to receive direction of care before the services are rendered.

ARTICLE VI - BENEFITS PROVIDED FOR MEDICAL CARE

6.1 Medical care under this Article shall be covered, subject to the limitations in Article III, only when such care is provided by a Plan Physician or arranged or approved by a Plan Physician with a Plan Provider, except in the event of a Medical Emergency or with a Preauthorized Referral.

6.1.1 Physical examinations and well-child care, which includes routine preventive checkups.

6.1.2 Prenatal, intrapartum and postnatal maternity care, including complications of pregnancy, of the Member and care with respect to the newborn child from the moment of birth for thirty-one (31) days including necessary care and treatment of illness, injury, and congenital defects of the infant. Coverage beyond thirty-one (31) days requires the child to be enrolled within thirty-one (31) days of his or her birthdate.

6.1.3 Medical eye / ear examinations (excluding refractions, which may be covered under Article IX).

6.1.4 Casts and dressings.

6.1.5 Immunizations.

6.1.6 Injections which are not usually self-administered.

6.1.7 Surgical care and anesthesia associated with it.

6.1.8 Health education services, which includes education about nutrition, and wellness programs approved by JDHP.

6.1.9 X-ray and laboratory tests and services, which includes pathology services and radiation therapy, for treating an illness or an injury.

6.1.10 Blood transfusion services.

6.1.11 Consultations.

6.1.12 Visits by a Plan Physician to a Member at his or her home or in a Nursing Facility.

6.1.13 All covered medical supplies which may be furnished in connection with the services provided above.

6.1.14 Direct access to a Plan Provider who is a licensed gynecologist and/or obstetrician for women's health care services as defined by the published recommendations of the Accreditation Council for Graduate Medical Education, which include, but are not limited to, diagnosis, treatment, and referral.

ARTICLE VII - PSYCHIATRIC, MENTAL HEALTH, ALCOHOLISM AND CHEMICAL DEPENDENCY BENEFITS

7.1 Hospital Services or medical care under this Article shall be covered, subject to the following limitations and those in Article III. Benefits are provided through contracts with selected treatment program providers. For benefits to be paid, a Member must be evaluated by a selected treatment program provider prior to commencement of treatment, except in the event of a Medical Emergency. The Member may call the local JDHP office for a list of the providers to be used and the procedures to be followed in order to receive services.

7.1.1 Inpatient Facility Services - If a Member is confined as a resident inpatient in a Plan Hospital, a non-acute hospital, or other JDHP authorized residential treatment facility and is enrolled in a treatment program authorized by JDHP for a psychiatric, mental, or nervous condition or disorder or for alcoholism or chemical dependency, benefits will be paid in an amount equal to the hospital's regular daily rate for semiprivate accomodations. In private accommodations, the Member shall pay directly to the Plan Hospital, the non-acute hospital, or the residential treatment facility the difference between its regular charge for the private room occupied and its most common charge for semiprivate accommodations. However, if a Plan Physician authorizes the private accommodations as medically necessary, the Member shall be entitled to full coverage.

7.1.2 Outpatient Facility Services - Outpatient facility services benefits will be paid if a Member shall receive necessary hospital outpatient medical services at a Plan Hospital, a non-acute Hospital, or other JDHP-authorized treatment facility and be enrolled in an JDHP-authorized outpatient treatment program for a psychiatric, a mental, or a nervous condition or disorder or for alcoholism or chemical dependency.

"Non-acute hospital" as used in this Article means a facility which is not licensed to operate as an acute care general hospital.

7.2 **Physician Services** - If a Member shall receive necessary psychiatric or professional services, which have been authorized in advance by the selected treatment program provider, fiom either: (1) a Plan Physician acting within the scope of his or her licensed authority, or (2) other licensed mental health provider with a Preauthorized Referral for a psychiatric, a mental or a nervous condition or disorder or for alcoholism or chemical dependency, benefits will be paid subject to the following provisions:

7.2.1 **Hospital Inpatient Physician Services** - Hospital inpatient physician services benefits will be paid if the Member is confined as a resident inpatient in a hospital as described in Article VII, 7.1.1.

7.2.2 **Hospital Outpatient Physician Services** - Hospital outpatient physician services will be paid if the Member shall receive necessary hospital outpatient services as described in Article VII, 7.1.2.

7.2.3 **Physician Office Services** - Physician office services benefits will be paid if the Member shall receive necessary physician office services.

7.3 **Benefits Not Provided** - Benefits shall not be provided under Article VII for any of the following incidents.

7.3.1 for any day of confinement, or service provided, or examination made which is not authorized by a Plan Physician, except in the event of a Medical Emergency or with a Preauthorized Referral.

7.3.2 for charges made by any person other than a Plan Provider unless approved by JDHP.

7.3.3 for charges incurred for services, other than diagnostic services, for mental retardation or for non-treatable mental deficiency.

7.3.4 for charges incurred for the treatment of a mental or a nervous disorder which is not subject to favorable modification by accepted psychiatric treatment, unless authorized by an Attending Physician.

7.3.5 for marital problems.

7.3.6 for family therapy, except as related to a covered service for another family member.

7.3.7 for learning problems.

7.3.8 for adult or childhood antisocial behavior without the manifestation of a psychiatric disorder.

7.3.9 for aggressive or nonaggressive conduct disorder without the manifestation of a psychiatric disorder.

7.3.10 for general counseling and advice.

7.3.1 1 for charges for personal and convenience items. Examples of such items are a telephone, a television, personal care items and personal services, or charges for diversional activities such as recreational, hobby or craft equipment or fees.

ARTICLE VIII - PERIOD AND EXTENT OF BENEFITS FOR EACH MEMBER

8.1 If a Member remains in a Plan Hospital or Nursing Facility after having been advised by a Plan Physician and notified by JDHP that his or her further confinement is medically unnecessary and that benefits will no longer be available, the Member shall be responsible for all of the charges which are'incurred for all services provided to him or her after he or she has been notified.

8.2 If any services that are not included in or covered by this Contract are provided to a Member, or if any Copayments or Coinsurance are established by JDHP, the Member shall make direct payment to the provider of such services.

ARTICLE IX – SCHEDULE OF VISION BENEFITS

9.1 Benefits will be paid, subject to the limitations and provisions listed below in this Article, for charges made by a Plan Provider for providing routine vision care to the Member. The Plan Provider, in this Article, must be either an ophthalmologist, an optometrist, or an optician.

9.2 JDHP will pay 100% of the Allowed Charge for a maximum of one (1) vision examination every twelve (12) months. A Plan Provider who is either an ophthalmologist or an optometrist must perform the examination. The examination includes an external examination of the eyes, refraction, binocular measure, ophthalmoscopic examination,

and tonometry when necessary, or recommendations including the prescription of lenses when they are necessary.

9.3 JDHP will pay for the materials prescribed as a result of the vision examination and provided by a Plan Provider. The materials may include contact lens, lenses, and/or frames, up to a maximum benefit of $100 one time in every twelve (12) months.

9.4 **Excluded** items, charges, or services are in the following list.

9.4.1 Lenses which do not require a prescription.

9.4.2 Charges for which benefits are otherwise provided under this Evidence of Coverage.

9.4.3 Procedures that are determined to be special or unusual such as, but not limited to, orthopics, vision training, subnormal vision aids, and aniseikonic lenses.

9.4.4 Eye glass cases.

9.4.5 Frames for nonprescription lenses.

9.4.6 Safety glasses for use by an employee on his or her job.

9.4.7 Charges for failed appointments.

9.4.8 Charges for the replacement of broken lenses or kames, unless at the time they are replaced the Member is eligible for new lenses or kames.

9.4.9 Services rendered or materials ordered after the date the Member ceases to be eligible for coverage. However, JDHP will pay benefits for lenses and frames which were prescribed prior to the cessation of coverage and which were delivered within 60 days of the date that they were prescribed.

9.4.10 Charges for materials or services which are not necessary, or which do not meet accepted standards of ophthalmic practice, or which are experimental in nature.

ARTICLE X – SCHEDULE OF DENTAL BENEFITS

10.1 Dental Benefits are payable for the billed charges, subject to Reasonable and Customary incurred for covered dental procedures. The procedures must have been furnished to the

Member while he or she was covered and the benefits must be determined by the list **of** "Covered Dental Services," according to this schedule:

Preventive services once every six *(6)* months	100%
Sealants	Up to a maximum of $10 per tooth
Primary services	100%
Major services	100%
Calendar Year Maximum Benefit	$1,000

Optional services or supplies that involve different charges may be proposed, rendered, or furnished. When that happens, the services or supplies which have the lesser charge, in accordance with accepted standards of dental practice, shall be considered the covered charge.

10.2 The charges must be a part of a Treatment Plan which, prior to the performance of the procedures, has been (a) submitted to JDHP and reviewed and (b) returned to the dentist showing estimated benefits. Submission of a Treatment Plan is not required, however, if the charges made or to be made total $250 or less, or if emergency care was required.

10.3 Subject to the conditions, the limitations, and the exclusions of the Contract and any other limitations specified in **this** schedule of dental benefits, a Member is entitled to the benefits for the following services which have been rendered and billed by a dentist or physician. Benefits will be provided in the **amounts,** if any, specified in the *summary* of dental benefits not to exceed the actual charge for the services rendered. No payment will be made until after receipt of the dentist's or physician's report for the service. In addition, benefits will be provided only if the services are rendered on or after the Member's effective date.

10.4 Covered Dental Services

10.4.1 Primary Services

10.4.1.1 Preventive Services

10.4.1.1.1 Initial oral examination, regardless of its Medical Necessity.

10.4.1.1.2 Periodic oral examinations, regardless of their Medical Necessity, not more than once during a period **of** six consecutive months.

10.4.1.1.3 Prophylaxis, regardless **of** its Medical Necessity, including cleaning, routine scaling and polishing not more than once during any period **of** six consecutive months.

10.4.1.1.4 Topical fluoride application **for** Members under age eighteen years, regardless of its medical necessity, not more than once during any period **of** six consecutive months.

10.4.1.1.5 Palliative emergency treatment and emergency oral examinations.

10.4.1.1.6 Dental x-rays consisting **of** a full mouth x-ray series once every 36 months and routine bitewing x-rays once every twelve months, regardless **of** their Medical Necessity.

10.4.1.2 Other Primary Services

10.4.1.2.1 Basic Primary Services limited to:

10.4.1.2.1.1 Fillings.

10.4.1.2.1.2 Simple extractions not requiring flap or bone removal.

10.4.1.2.1.3 Endodontics

10.4.1.2.1.4 Pulp vitality tests, not more than once during any twelve consecutive months.

10.4.1.2.1.5 Stainless steel crowns to restore a primary tooth when the tooth cannot be restored by a filling.

10.4.1.2.1.6 Temporary crowns for tooth fracture while a permanent crown is constructed.

10.4.1.2.2 Additional Primary Services limited to:

10.4.1.1.6.1 Removal of soft tissure, partial or full bony impacted teeth.

10.4.1.1.6.2 Space maintainers up to age nineteen years, excluding orthodontics.

10.4.1.1.6.3 Apicoectomy.

10.4.1.1.6.4 Hemisection.

10.4.1.1.6.5 General anesthesia administered in connection with a covered dental service only if administered by an individual licensed to administer general anesthesia.

10.4.1.1.6.6 Periodontics limited to:

10.4.1.1.6.6.1 Gingivectomy and gingivoplasty.

10.4.1.1.6.6.2 Root scaling/planing.

10.4.1.1.6.6.3 Osseous surgery, including flap entry and closure.

10.4.1.1.6.6.4 Surgical periodontic examination.

10.4.1.1.6.6.5 Mucogingivoplasty surgery.

10.4.1.1.6.6.6 Management of acute periodontal infection and oral lesions.

10.4.2 Major Services

10.4.2.1 Inlays (not part of bridge)

10.4.2.2 Onlays (not part of bridge)

10.4.2.3 Crowns (not part of bridge)

10.4.2.3.1 Benefits for crowns for individual teeth are payable only when the tooth is broken down due to decay or trauma or when an endodontic procedure is performed.

10.4.2.3.2 Benefits will not be provided for the replacement of a defective or lost crown inserted after the coverage date, until five years have elapsed from the date of insertion.

10.4.2.4 Dentures (full and partial) and bridges (fixed and removable) subject to the following:

10.4.2.4.1 Benefits for replacement of an appliance will not be provided for any replacement made less than five years after a placement or replacement which was covered under this benefit section or for dentures or bridges which are able to be made serviceable; and

10.4.2.4.2 If, in the construction of a denture or a bridge, the Member and dentist decide on personal restorations or to employ specialized techniques as opposed to standard procedures, the benefits provided will be limited to the standard procedures for prosthodontic services as reasonably determined by JDHP.

10.4.2.5 Denture adjustments and relining, for which benefits are limited, during the first six months following denture placement, to services rendered by a dentist or physician other than the dentist or physician who provided or repaired the appliance.

10.4.2.6 Fixed bridge repairs.

10.4.2.7 Repair of full and partial dentures.

10.4.2.8 Recementing of crowns, inlays, and/or bridges.

10.4.3 Sealants, or the application of a polymer topical sealant as a caries preventive measure, will be reimbursed at the actual covered charge, subject to Reasonable and Customary, or a scheduled benefit of $10 per tooth, whichever is less, subject to the following limitations:

10.4.3.1 Sealant coverage will apply only to sealants applied to the occlusal fissures of permanent molars within four years of eruption. This is by age ten years for first molars, by age fifteen years for second molars.

10.4.3.2 The sealing of premolars and primary molars will not be reimbursed.

10.4.3.3 Teeth to be sealed must be free of proximal caries and there can be no previous restorations on the surface to be sealed.

10.4.3.4 One replacement per sealed tooth can be accepted for reimbursement within the first six months, and one more replacement can be reimbursed each subsequent three-year interval.

10.5 Dental coverage exclusions; coverage does not apply to:

10.5.1 Injury arising out of or in the course of any employment, including self-employment, for wage or profit;

10.5.2 Dental services or supplies that are solely cosmetic in nature, such as but not limited to, personalization or characterization of dentures. Facings on crowns or pontics behind the second molar will always be considered cosmetic. Dental *care* for cosmetic purposes will be paid if due to an accidental dental injury;

10.5.3 Cosmetic dental care of a congenital or developmental malformation (including congenitally missing teeth);

10.5.4 An orthodontic service unless provided for elsewhere in this Contract;

10.5.5 Replacement of lost or stolen appliances;

10.5.6 Dental care for the purpose of altering vertical dimension, restoring occlusion, splinting or replacing tooth structure lost as a result of abrasion or attrition;

10.5.7 Treatment of disturbances of the temporomandibular joint except as specifically provided in the list of Covered Dental Procedures;

10.5.8 Dental care which is not customarily performed or which is experimental in nature;

10.5.9 A service not furnished by a dentist or dental hygenist, unless it is for an x-ray ordered by a dentist;

10.5.10 Dental care paid for, required or provided by or under the laws of a national, state, local, or provincial government, or treatment furnished within a hospital or

other facility owned or operated by a national or state government, unless the Member has a legal obligation to pay;

10.5.11 Replacement of an appliance or prosthetic device, crown, cast restoration, or fixed bridge within five years of the date it was last placed if JDHP has paid for the initial or the previous placement. This exclusion will not apply if a replacement is needed due to an accidental injury received while insured;

10.5.12 Any services, treatment or supplies which may be included as an eligible benefit under any other benefit section of this Contract;

10.5.13 Charges for failure by the Member to keep a scheduled visit with the dentist;

10.5.14 Services provided by dental laboratories;

10.5.15 An initial placement of a partial or full removable denture or fixed bridgework if that involves replacement of one or more teeth which were extracted more than six months prior to the Member's becoming insured under this coverage, unless the denture or fixed bridgework also includes the replacement of a natural tooth which was extracted within six months of this coverage's effective date, This will not apply if this Contract is replacing a dental contract which was in force immediately prior to this Contract;

10.5.16 In the event a Member transfers from the care of one dentist to the care of another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, JDHP will be liable for not more than the amount it would have been liable for, had but one dentist rendered all of the service.

10.6 Extension of Benefits in Case of Termination – Benefits will be provided under this dental benefit section after the date of the Member's termination under the contract for a prosthetic device which was fitted prior to such termination and which is installed or delivered within 60 days of such termination.

ARTICLE XI – SCHEDULE OF OUTPATIENT PRESCRIPTION DRUG BENEFITS

11.1 Definitions

11.1.1 "Co-Marketed Drug" means an equivalent brand name Outpatient Prescription Drug that contains the same active ingredient(s) and that is available from more than one pharmaceutical company.

11.1.2 "Compounded Prescription" means an Outpatient Prescription Drug: a) which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA); and b) which contains at least one ingredient that is classified as an Outpatient Prescription Drug. **JDHP must grant its Prior Authorization for any benefit to be payable for a Compounded Prescription.**

11.1.3 "Direct Member Reimbursement'' means that the Member pays for an Outpatient Prescription Drug at a pharmacy. Then the Member submits the receipt to JDHP to be reimbursed.

11.1.4 "Network Pharmacy" means a licensed pharmacy that has entered into an agreement with JDHP to dispense covered drugs to Members.

11.1.5 "Outpatient Prescription Drug" means a drug which has been approved by the FDA for specific indications and which can, under Federal or State law, be dispensed only pursuant to a Prescription Order. Such a medication is labeled "Caution.. .Federal law prohibits dispensing without a .prescription (a legend medication)." Insulin and disposable insulin syringes will be considered an Outpatient Prescription Drug for the purposes of payment pursuant to this section.

11.1.6 "Prescription Fill" means the initial quantity of an Outpatient Prescription Drug which is dispensed as the result of a Prescription Order.

11.1.7 "Prescription Refill" means a subsequent quantity of an Outpatient Prescription Drug which is dispensed after the initial Prescription Fill.

11.1.8 "Prescription Order" means an authorization for the dispensing of an Outpatient Prescription Drug. A medical practitioner, who is duly licensed to make such an authorization in the ordinary course of his or her professional practice, issues it.

11.2 Covered Drugs

11.2.1 Outpatient Prescription Drugs (including insulin and disposable insulin syringes) are covered drugs. Prescriptions must be dispensed in accordance with the terms of this Article. They must not be otherwise excluded from coverage based upon the exclusions listed either in this section or elsewhere in the Evidence of Coverage.

Outpatient Prescription Drugs will be covered for FDA-approved indications. They will also be covered for non-FDA-approved indications if the use is a

commonly accepted standard of care as indicated by the following official compendia: United States Pharmacopeia Dispensing Information, American Medical Association's Drug Evaluation, or American Hospital Formulary Service. Examples include, but are not limited to:
Pulmozyme will be considered a covered drug only for the FDA-approved indication of cystic fibrosis. ***Retin A*** will be considered a covered drug only for the FDA-approved indication of acne vulgaris.

11.2.2 Outpatient Prescription Drugs which may be covered under this section must be dispensed as the result of a Prescription Order authorized: a) by a Plan Provider; or b) by a Non-Plan Provider with Preauthorized Referral; or c) by a Plan or Non-Plan Provider in the event of a Medical Emergency.

11.3 Copayments – Outpatient Prescription Drugs are subject to the following Copayment schedule:

11.3.1 No Copayment applies if:

11.3.1.1 A Network Pharmacy dispenses a generic drug; or

11.3.1.2 A Network Pharmacy dispenses disposable insulin syringes; or

11.3.1.3 A Network Pharmacy dispenses diabetic supplies such as lancets, glucose testing tablets and strips; or

11.3.1.4 A Network Pharmacy dispenses Coumadin, Dilantin, Lanoxin, Synthroid, or Tegretol; or

11.3.1.5 A Network Pharmacy dispenses a brand name medication which does not have an A-rated generic equivalent.

11.3.2 The Member will be responsible for the FULL COST of the Prescription Drug if:

11.3.2.1 A Network Pharmacy dispenses a brand name medication which has an A-rated generic equivalent.

11.3.3 The classifications of a brand name medication and a generic medication are determined, and subject to continual review and modification, by First Data Bank.

11.4 Outpatient Prescription Drug Benefit exclusions:

11.4.1 Medications available over the counter (OTC) that do not require a prescription.

11.4.2 Drugs which are entirely consumed at the time and place of prescribing.

11.4.3 Charges for the administration or the injection of any medication.

11.4.4 Any type of therapeutic or prosthetic device, appliance, support or hypodermic syringe (other than disposable syringes to inject insulin), even though such device, appliance, support or syringe may require a prescription. Such items may be payable as Durable Medical Equipment as described in Article V of this Evidence of Coverage.

11.4.5 Drugs which are dispensed to a Member while he or she is an inpatient in a facility such as a hospital or a similar institution when such an institution dispenses and bills for the medications it has used during the Member's confinement.

11.4.6 The replacement of lost, stolen, broken or discarded medications.

11.4.7 Drugs labeled "Caution...Limited by Federal Law to Investigational Use"; experimental drugs; or FDA-approved medications in experimental or non-FDA-approved dosage forms, or for non-approved or experimental indications.

11.4.8 Medications which were dispensed prior to the Effective Date, or after the termination date, of a Member.

11.4.9 Medications which were dispensed by a facility other than a licensed pharmacy.

11.4.10 Drugs which are used for the treatment of infertility.

11.4.11 Growth hormone, regardless of the intended use.

11.4.12 Medication which is prescribed for cosmetic purposes including, but not limited to any of the following:

Tretinoin (Retin A) if it is used to treat wrinkled or photo-aged skin.
Tretinoin (Renova) regardless of the intended use.
Anabolic steroids used to enhance physical appearance or athletic performance.

11.4.13 Dietary supplements, medications or treatment used for appetite suppression or weight loss, and nutritional supplies (e.g., Sustacal, Ensure, Meridia).

11.4.14 Smoking deterrents, nicotine replacement products, medication, aids, treatment or supplies for nicotine or to promote smoking reduction or cessation.

11.4.15 Injectable medications that are not typically self-administered by the Member.

11.5 Limitations

11.5.1 The prescription quantity shall be limited to the lesser of the amount that is necessary to treat the episode or the condition for which the Outpatient Prescription Drug was prescribed, or a 30-day supply.

11.5.2 A Member will be considered to have an adequate supply of medication from the previous dispensing date and will not be eligible for a Prescription Refill if an insufficient number of days have elapsed between fills, as determined by JDHP.

11.5.3 JDHP reserves the right to limit the quantity dispensed per Prescription Fill and the frequency of Prescription Fills or Refills to a reasonable amount for a specified condition or episode. JDHP reserves the right to limit quantities of medications dispensed to the usual dosing frequency approved by FDA.

11.5.4 Subject to physician authorization, JDHP reserves the right to require the substitution of a therapeutically equivalent product when it is clinically appropriate.

ARTICLE XII - EXCLUSIONS APPLICABLE TO THE ENTIRE PLAN

In addition to any exclusion listed under the individual Articles of this Contract, JDHP shall not provide benefits for any of the following items or services.

12.1 Any service or any treatment, hospital, medical, or otherwise, which is not provided by a Plan Physician or arranged or approved by a Plan Physician with a Plan Provider, except in the event of a Medical Emergency or with a Preauthorized Referral.

12.2 Special nurses and attendants, except to the extent provided under Home Care Services.

12.3 Care for a condition that federal, state or local law requires to be treated in a public facility, a hospital or other health care facility.

12.4 Custodial care due to the Member's condition. "Custodial" means that his/her care consists of watching, maintaining, or protecting, **or** is for the purpose of providing personal needs. **JDHP** does not pay for a person to provide any of, but not limited to, the following help, care, or service.

12.4.1 Assistance in the activities of daily living, such **as** walking, dressing, getting in and out of bed, bathing, eating, feeding or using the toilet or help with other functions of daily living or personal needs of a similar nature.

12.4.2 Changes of dressings, diapers, protective sheets or periodic turning or positioning in a bed.

12.4.3 The administration of or help in using or applying medications, creams and ointments, whether oral, inhaled, topical, rectal or injection.

12.4.4 The administration of oxygen.

12.4.5 Care or maintenance in connection with a cast, a brace, or other similar device.

12.4.6 Care in connection with ostomy bags or devices or in-dwelling catheters.

12.4.7 Feeding by tube including the cleaning and care of the tube site.

12.4.8 Tracheostomy care including the cleaning, suctioning and care of the site.

12.4.9 Urinary bladder catheterization.

12.4.10 The monitoring, routine adjustments, maintenance or cleaning of an electronic or mechanical device which is used to support a physiological function including, but not limited to, a ventilator, phrenic nerve or diaphragmatic pacer.

12.4.11 The general supervision of exercise programs including the carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

12.5 Services for convenience, comfort, appearance, educational, recreational or vocational reasons.

12.6 Any Hospital Services, physician care or surgery as the result of cosmetic, beautifying, reconstructive or plastic surgery, or care primarily provided for the aging process, including any complications arising fiom such care. However, JDHP will pay benefits for reconstructive surgery due to either of the following reasons.

12.6.1 When such service is incidental to or follows surgery which has resulted in a defect as a result of some trauma, infection or other disease of the involved part.

12.6.2 Because of a congenital disease or an anomaly which has resulted in a functional defect.

12.7 Any fees for the services of a Non-Plan Provider if the fees or charges for those services are claimed by hospitals, laboratories, or other institutions or for the service of any assisting physician who was not authorized by a Plan Physician.

12.8 Hearing aids except as provided in a supplemental benefit rider if one is attached to this Evidence of Coverage, or any augmentative communication device.

12.09 Special shoes unless they are an integral part of a brace, or corsets or other articles of clothing and cosmetic devices.

12.10 Treatment that is provided in a government hospital; or treatment covered by any state or federal workers' compensation, employer's liability or occupational disease law.

12.11 Services that a Member performs for a Member's immediate family; and services for which no charge is normally made.

12.12 Any service which can be performed in the setting by a person who does not have professional qualifications but who has been trained to perform the service.

12.13 Experimental or investigational drugs, devices, medical treatment or procedure. A drug, a device, a medical treatment or a procedure is experimental or investigational if it is described by any one of the following three paragraphs.

12.13.1 The drug or the device requires approval of the Food and Drug Administration and the drug or the device has not been approved when it is furnished (a drug or a device that is approved for investigational use is deemed to be experimental or investigational).

12.13.2 Reliable evidence shows that the drug, the device, the medical treatment or the procedure is the subject of ongoing phase I, II, or III clinical trials for the Member's medical condition except for National Cancer Institute-approved phase III clinical trials for cancer.

12.13.3 Reliable evidence shows that the consensus of opinion among experts regarding the drug, the device, the medical treatment or the procedure is that further studies or clinical trials are necessary to determine its maximum tolerated doses, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis for the Member's medical condition.

"Reliable evidence" shall mean only the published reports and the articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure, or the written informed consent that that treating facility uses or that another facility, studying substantially the same drug, device, treatment or procedure, uses.

12.14 Charges for any one or more of the following types of treatment, care, service, or therapy. Biofeedback treatment. Holistic medicine. Acupuncture. Hypnotherapy. Sleep therapy. Vocational, rehabilitational or employment counseling. Marriage and sex counseling. Behavior training, conduct disorders and related family counseling. Remedial education and treatment of learning disabilities.

12.15 Charges for ergometers, exercise bikes, or other similar devices.

12.16 Charges for weight loss clinics or programs unless they are a part of a JDHP-approved wellness program.

12.17 Charges for sickness contracted or injuries sustained as the result of war, declared or undeclared, or any act or hazard of war.

12.18 Charges for sickness contracted or injuries sustained as the result of or while in the armed services of any country to the extent that the Member is entitled to coverage for such sickness or injury through any governmental plan or program except Medicaid.

12.19 Hospital or physician services or treatment which is provided as a result of an order by a court, unless it is approved in advance by a Plan Physician.

12.20 Charges which are incurred in connection with assisted reproduction techniques, such as, but not limited to, any one or more of the following techniques. In vitro fertilization. The reversal of vasectomies. The reversal of tubal ligations. The reversal of other voluntary sterilization procedures. JDHP will also not cover any complications arising from any such technique.

12.21 Any treatment or procedure related to the performance of gender transformation. JDHP will also not cover any complications arising from such a procedure.

12.22 Surgery to the cornea to improve vision by changing the refraction such as, but not limited to, radial keratotomy. JDHP will also not cover any complications arising from such surgery.

12.23 Charges for any devices used in conjunction with birth control. This rule is without regard for the intended use of any such device.

12.24 Any health care services that a motor vehicle no-fault insurance policy or other liability or equivalent self-insurance covers.

12.25 Charges for long-term physical therapy and rehabilitation.

12.26 Charges for chiropractic treatment, except With a Preauthorized Referral.

ARTICLE XIII - GENERAL CONDITIONS UNDER WHICH BENEFITS SHALL BE PROVIDED

13.1 The benefits of this Contract are subject to the rules and regulations described in it. JDHP shall not have liability or obligation for services that are not provided by a Plan Physician except in the event of a Medical Emergency or with a Preauthorized Referral.

13.1.1 The Member is required to choose a Primary Care Physician from the list of JDHP Primary Care Physicians, which includes family practitioners, general practitioners, internists, pediatricians or a physician specializing in obstetrics or gynecology. The Primary Care Physician who is selected will accept the Member as a patient as his or her practice permits. The Member is encouraged to use that Primary Care Physician for medical care, though the Member may self-refer to another Plan Provider to receive such care.

13.1.2 The Member has the right to change his or her Primary Care Physician by giving JDHP 30 days' notice. The notice to JDHP can be made in writing or by calling 1-800-247-9110 or the telephone number of the JDHP office on the back of the

membership card. **A** hearing-impaired Member may call Member Services at either of the following TDD* telephone numbers: a) toll-free **1-800-884-4327** or b) local number in Moline, Illinois **309-765-0499.** (*TDD means Telecommunications Device for the Deaf.)

The change will be effective on the first day of the month following **30** days' notice. The approval of JDHP is not required.

13.1.3 In order to receive benefits for covered services under this plan, the Member must receive those medically necessary services fiom Plan Providers. The Primary Care Physician is trained to handle the majority of common health care needs; however, there may be a time when he or she feels the Member needs more specialized treatment. In that case, the Primary Care Physician will refer the Member to an appropriate specialist. **As** long **as** the Member has a Preauthorized Referral fiom the Primary Care Physician or fiom a Plan Physician, JDHP will cover those services even if a Non-Plan Provider furnishes them.

If the Member obtains services from a Non-Plan Provider without a Preauthorized Referral, JDHP will not cover those services, except in the event of a Medical Emergency.

13.2 JDHP shall arrange payment for the professional services included under this Contract. JDHP shall pay the provider of the services. However, at the sole discretion of JDHP, JDHP may reimburse the Member directly in the case of out-of-area services or Emergency Services for which the Member has already paid and furnished a receipt.

13.3 Hospital Service is subject to all the rules and regulations of the Plan Hospital or Nursing Facility, including the rules and regulations governing admission and discharge. No inpatient or outpatient services will be covered if the admission or other services are provided by a Non-Plan Provider except in the event of a Medical Emergency or with a Preauthorized Referral.

13.4 The Member agrees that any health care provider who has treated the Member in connection with any ailment is authorized to furnish to JDHP all of the information and records, or copies of records, to the extent permitted by law, relating to such diagnosis, treatment, or services. The Member further agrees that JDHP may refer to **a** provider all such information and records that JDHP has received.

13.5 The Member agrees to submit any Grievance or complaint regarding this Contract or the provision of benefits under this Contract for resolution in accordance with the Grievance procedure which JDHP has established. The Grievance procedure is set forth in Article XIX.

13.6 The Member agrees that, in the event that the Plan Physician for the Member ceases to be a Plan Physician, the Member shall choose another Plan Physician. In addition, if the Primary Care Physician terminates his or her relationship with JDHP, then JDHP will assist the Member in selecting another Primary Care Physician.

13.7 In the event of any major disaster or epidemic, war, riot or labor dispute, JDHP shall provide the Hospital and the medical services provided under this Contract in so far as practical, according to its best judgment, within the limitations of such facilities and such personnel as are then available. Under such conditions JDHP shall not have any liability or obligation for a delay or a failure to provide or arrange for the Hospital or the medical services due to a lack of available facilities or personnel.

ARTICLE XIV - RELATIONS AMONG PARTIES AFFECTED BY THE AGREEMENT

14.1 The relationship between JDHP and any other organization having a contract with JDHP is an independent contractor relationship. No such organization or its employee or its agent is an employee or agent of JDHP. Neither JDHP nor any employee or agent of JDHP is an employee or agent of such organization.

14.2 Plan Physicians maintain the Physician-patient relationship with Members. They are solely responsible to Members for all medical services.

14.3 The Member is not an agent or representative of JDHP. He or she shall not be liable for any acts or omissions of JDHP, its agents or its employees, or any other person or organization with which JDHP has made, or in the future shall make, arrangements for the performance of services under this Contract.

14.4 JDHP has entered into a service agreement with its parent, John Deere Health Care, Inc. (JDHC). JDHC provides all administrative services for JDHP.

ARTICLE XV - CONFIDENTIALITY

15.1 Information from the medical records of Members and information from Physicians and hospitals incident to the Physician/patient relationship or hospital/patient relationship shall be confidential. JDHP will not disclose it without the prior written consent of the Member. However, JDHP or its designated agent may release such information without

the prior written consent of the Member for use in: (1) the processing of claims for payment; (2) peer review, utilization review, medical audit or any other program established by JDHP for quality health care and control of health care costs; (3) bona fide medical research'and education and (4) which is conducted by JDHP or its designated agent.

ARTICLE XVI - CLAIM PROVISIONS

16.1 Except as set forth in Article III, it is not anticipated that a Member will make payment to any person or institution providing benefits under this Contract beyond any applicable Copayments and Coinsurance. However, if the Member furnishes evidence satisfactory to JDHP that he or she has made a payment with respect to charges for benefits under this Contract, the payment for those charges will be made to the Member. In no event will the amount of the payment to the Member exceed the maximum benefit payable by JDHP less any applicable Copayments and Coinsurance.

16.2 If a charge is made to a Member for any service with respect to the benefits under this Contract beyond any applicable Copayments and Coinsurance, then he or she should furnish written proof of such charges to JDHP within 90 days from the date of the service. JDHP will not make the payment for such charges to the Member if he or she submits the evidence of the payment more than fifteen months after the date of the service.

ARTICLE XVII - TERMINATION

17.1 The Program Administrator is responsible for notifying a Member of his or her termination, as state in Article II. The Program Administrator also completes that termination, as stated in Article II. However, JDHP may request termination of this contract at any time for one or more of the following reasons.

17.1.1 Upon the death of the Member, this Contract shall automatically terminate.

17.1.2 The misrepresentation of a material fact in enrolling or making a claim for benefits under this Contract. Under such circumstances, JDHP shall have the right to recover the full amount of any benefits paid on behalf of the Member.

17.1.3 The unauthorized use of a Member's JDHP identification card by any other person. In such a cake, JDHP may retain the card and all the rights of the Member shall terminate.

17.1.4 Failure of the Member to pay Copayments and/or Coinsurance.

17.1.5 Failure of the Member and the Plan Physician to establish a satisfactory relationship including, but not limited to, the refusal of the Member to follow a prescribed course **of** treatment and/or instruction **as** established by a Plan Physician. Such a failure shall'not be deemed good cause unless **JDHP** has, in good faith, made an effort to provide the opportunity for the Member to establish a satisfactory patient-physician relationship, including the assigning of the Member to another Plan Physician.

17.1.6 A change in the Member's place of residence that locates the Member outside the Service ***Area*** defined in Article I. If a Member moves out of the Service Area, this Contract shall immediately terminate.

17.2 **JDHP** shall give the Member an immediate written notice of termination if the Member engages in activities which endanger the safety and welfare of **JDHP** or its employees or its providers.

17.3 Upon the termination of his or her enrollment **as** provided in this Article and Article II, the Member shall with no delay cease to be entitled to any benefits. However, if the Member is receiving benefits under this Contract in **a** hospital or **a** Nursing Facility at the time of such termination, the Member shall be entitled to the continuation of benefits under Article **IV** or Article **VII, 7.1.1,** whichever is applicable, subject to the terms and the conditions of this Evidence of Coverage, for that confinement.

ARTICLE XVIII - REINSTATEMENT AND MISCELLANEOUS PROVISIONS

18.1 At its sole discretion, JDHP may reinstate any Contract which is terminated in any manner **as** provided in this Evidence of Coverage.

18.2 The benefits **of** this Contract are personal to the Member and cannot be assigned.

18.3 The cards issued by JDHP to Members in accordance with this Contract are for identification only. Possession of a JDHP identification card confers no right to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf JDHP has actually paid all applicable charges under this Contract. Any person receiving services or other benefits to which he or she is not entitled in accordance with the provisions of this Contract shall be charged at prevailing rates.

18.4 JDHP may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract.

18.5 This Contract constitutes the entire Contract between the parties and, as of its Effective Date, it supersedes all other agreements, oral or otherwise, between the parties regarding the subject matter contained in the Contract.

18.6 No agent or other person, except an officer of **JDHP,** has authority to waive any of the conditions or restrictions of this Contract; to extend the time for making a payment; or to bind JDHP by making any promise or representation or by giving or receiving any information. No change in this Contract shall be valid unless there is an endorsement on it that one of JDHP's officers has signed, and the change has been filed with the Iowa Insurance Division or other appropriate regulatory agencies of the State of operation.

ARTICLE XIX - MEMBER COMPLAINT, GRIEVANCE AND ARBITRATION PROCEDURES

19.1 These procedures provide a system for resolving a complaint and/or grievance of a Member concerning the provision of health care services or other matters concerning the operation of JDHP.

19.2 These procedures shall not apply to any complaint, grievance or arbitration which alleges or indicates possible professional liability, commonly known as "malpractice," nor to any complaint or grievance concerning benefits provided by other than JDHP (under the provisions of any indemnity policy or contract provided by JDHP), except for the recording of such complaint or grievance required by law to be reported to the Iowa Insurance Division or other regulatory agency of any State having jurisdiction over JDHP.

19.3 The Member Complaint Procedure shall be as follows:

19.3.1 If a Member cannot satisfactorily resolve a problem on an informal basis by consulting with JDHP staff and/or the health care practitioner from whom the Member has received services, the Member may file a written "Member Complaint Form," which JDHP shall provide upon the written or oral request of the Member. The form shall be filed within 90 days from the date the problem in question occurred. The complaint form shall be signed and the facts as alleged shall be binding on the Member. The complaint form shall be filed by mailing or hand-delivering to JDHP's location nearest the Member's residence or to:

Customer Service, Appeal Department
3800 23rd Avenue, Suite 200
Moline, Illinois 61265

JDHP shall issue a decision, in writing, to all parties involved within fourteen days. The written decision shall be extended in the event of a delay in resolving the complaint that is beyond JDHP's control. JDHP shall notify the member with the reasons for the delay. JDHP shall maintain a written log of all complaints received and the subsequent actions taken. If the Member is disabled and/or needs help with completing his or her complaint, he or she can obtain assistance by contacting the Customer Service number on the ID card (*TDD-1-800-884-4327, local in Moline, IL – 765-0499, for persons with hearing problems).

*TDD – Telecommunications Device for the Deaf.

19.4 The Member Grievance Procedure shall be as follows:

19.4.1 If the Member is not satisfied with the outcome of the decision, he or she has fourteen days from the date the decision was issued in which to file a formal appeal to the Member Grievance Committee of JDHP. JDHP shall issue a written acknowledgment to the Member of receipt of his or her grievance within ten business days of such receipt. JDHP shall give consideration to the Member's request for the date and time of the Member Grievance Committee meeting where the committee shall hear the Member's appeal. The meeting shall be held at JDHP's main office. The Member Grievance Committee shall hear each party to the complaint and/or his or her representative. The Member shall be given an opportunity to appear in person or to communicate with the Committee by conference call or other appropriate technology.

JDHP shall notify the Member, at the time of the hearing, of the name and affiliation of the Member Grievance Committee members who are JDHP representatives. JDHP shall not present any evidence without the Member having been given the opportunity to be present. Each party may present his or her case as to why the decision rendered should be sustained or rejected. The Member shall have the right upon written request to review all relevant documents. The Member may submit issues and comments in writing.

Upon conclusion of the presentation of all arguments, the Member Grievance Committee shall have the authority to resolve the grievance, by majority vote. The review by the Grievance Committee will happen within 45 days of receiving the request. The determination by the Member Grievance Committee shall be extended for a period not to exceed 30 days in the event of a delay in obtaining the documents or the records necessary for the resolution of the grievance. JDHP shall furnish written notice of the determination to the Member within five business days following the decision.

19.4.2 Where it is allowed by law, the filing of a grievance with JDHP shall not prevent the Member from filing a complaint with the Iowa Insurance Division nor shall it prevent the Iowa Insurance Division from investigating a complaint in accordance with its authority.

19.4.3 Prior to the resolution of a Grievance filed by a Member, JDHP shall not terminate coverage for any reason which is the subject of the written Grievance, except where ***JDHP*** has, in good faith, made a reasonable effort to resolve the written grievance through the Grievance procedure and JDHP is terminating coverage **as** provided in Article XVII.

19.4.4 If the Member declines to accept the Member Grievance Committee's decision, the Member may request arbitration.

19.4.5 For further information, the Member may contact the Program Administrator at its address shown in Attachment A or the Iowa Insurance Division at:

Iowa Insurance Division
Lucas State Office Building
Des Moines, Iowa **50319**

19.5 The Arbitration procedure shall be **as** follows:

19.5.1 If the Member is dissatisfied with the decision of the Member Grievance Committee, he or she must file a request for arbitration with JDHP in writing within six months **of** the date **of** the decision. Only the Member may request arbitration. Arbitration is not available on behalf of JDHP.

19.5.2 Arbitration shall be conducted in accordance with the Rules of the American Health Lawyers Association Alternative Dispute Resolution Service. The question for the arbitrator will be whether the decision of the Member Grievance Committee to deny the claim should be set aside because the decision **was** arbitrary and capricious. Judgment upon the decision by the arbitrator may be entered in any court having jurisdiction. Each party will bear its own costs and attorney fees. Both parties will share equally the expenses associated with the arbitration. Arbitration is final and binding on the parties.

19.5.3 The parties waive their right to seek remedies in court, including their right to jury trial, except for enforcement of the decision of the arbitrator. The Member and JDHP agree that the arbitrator shall have no authority to award punitive and/or exemplary damages and waive their right to such damages.

ARTICLE XX - NOTICE

20.1 Any notice given by **JDHP** to the Member shall be sufficient if mailed to the Member at his or her address as it appears on the records of JDHP. It is the Member's responsibility to notify JDHP of any and all changes in address. Any notice shall be deemed delivered when deposited in the United States mail at any post office or postal box with first class postage prepaid.

ARTICLE XXI - THIRD PARTY LIABILITY

21.1 In the event of any payment of benefits for which a Member may have a claim or a cause of action against any person or organization, **JDHP** shall be subrogated to all right of recovery of the Member with respect to any judgment, payment or settlement for personal injury. The Member agrees to do each of the following actions.

21.1.1 to fully cooperate with **JDHP** in obtaining information about the **loss** and its cause.

21.1.2 to notify JDHP of any claim for damages made or any lawsuit filed on behalf of the Member in connection with the **loss.**

21.1.3 to include the amount of the benefits paid by JDHP on behalf of the Member in the claims for damages against other parties.

21.1.4 to notify JDHP of a proposed settlement at least thirty **(30)** days before any claim or lawsuit is settled in regard to the loss.

21.1.5 to provide JDHP with a lien, to the extent of the cash value of these services and supplies provided. Such lien may be filed with the person whose act caused the injuries, his or her agent or a court having jurisdiction in the matter; and

21.1.6 to reimburse JDHP from any damages collected to the extent of the reasonable cash value of the services and the supplies furnished under this Contract for such injuries. The Member will make the reimbursement immediately upon the collection of damages with respect to such Member, whether by action of law, settlement or otherwise; and

21.1.7 to pay JDHP all of the costs and expenses, including attorney's fees, which JDHP incurred or expended in obtaining or attempting to obtain the payment from the Member if the Member fails or refuses to reimburse JDHP according to this provision; and

21.1.8 to permit JDHP to file a lawsuit in the name of the Member against the person whose act caused the injuries.

21.2 Any judgment, payment or settlement shall first reimburse JDHP, regardless of whether the Member will receive full compensation. If any amount then remains, the Member shall receive it.

ARTICLE XXII - DISCRETIONARY AUTHORITY OF JDHP

22.1 JDHP has discretionary authority to determine the eligibility for benefits and to construe and interpret all the terms and the provisions of this Contract. JDHP may delegate its discretionary authority to another person, partnership, corporation or other legal entity.

ATTACHMENT A: to ARTICLE II

The name, address, and telephone number of the Program Administrator is:

Eligibility Services Incorporated
P.O. Box 71336
Des Moines, IA 50325
800-257-8563

ATTACHMENT B: to ARTICLE I

The counties included in John Deere Health Plan, Inc.'s Service Area are:

Benton
Blackhawk
Butler
Cedar
Clayton
Dallas
Delaware
Dubuque
Grundy
Jackson
Jones
Linn
Madison
Polk
Scott
Warren

Healthy and Well Kids in Iowa (HAWK-I)

JOHN DEERE HEALTH PLAN, INC.

Member Handbook

JOHN DEERE
HEALTH

JOHN DEERE HEALTH

''ealthy and Well Kids 'n Iowa (HAWK-I)

JOHN DEERE HEALTH PLAN, INC

Welcome to

JOHN DEERE HEALTH PLAN, INC.

John Deere Health Plan, Inc. is a Health Maintenance Organization (HMO) that has contracted with the State of Iowa to provide you with health care coverage through the Healthy and Well Kids in Iowa (HAWK-I) Program. An HMO is a health plan that organizes health care for members like you. John Deere Health Plan gives you health care when you're sick or hurt, but also preventive health care to keep you healthy. You get health counseling and regular health, dental, and vision services to keep you well.

We mailed a provider directory listing the contracted doctors, pharmacies, hospitals and other health care professionals in your area with this member handbook. We also included an Evidence of Coverage (EOC). It's important that you read the EOC to understand how your health care plan works. This member handbook gives you general information about your health care coverage, special programs and your rights and responsibilities as a member. The EOC provides you more detailed information about the plan, including definitions and benefit summaries. If you have any questions, please call your local Customer Service Department at the number listed on your member ID card.

YOUR RIGHTS AND RESPONSIBILITIES

As a member of John Deere Health Plan, you have certain rights in regard to the medical services you receive, such as access, service, medical care and confidentiality. These rights are outlined in the Enrollee Bill of Rights.

Along with these rights, you have certain responsibilities for cooperating with those who provide your care. These responsibilities are outlined in the Enrollee Responsibilities.

Enrollee Bill Of Rights

1. You have the right to receive services that are prompt, convenient, and suitable for your medical needs.

2. You have the right to emergency services when they are medically necessary. Emergency services are available 24 hours a day, seven days a week.

3. You have the right to receive information about your health problems, about treatment options and about treatment risks.

4. You have the right to information that is easy to understand so you can make an informed choice.

5. You have the right to have your medical records and financial records kept private by John Deere Health Plan and any participating provider, as allowed by law.

6. You have the right to file a complaint (grievance) with John Deere Health Plan or with the State of Iowa Insurance Commissioner.

7. You have the right to be treated privately, with respect and dignity.

8. You have the right to participate in decisions regarding your health care.

9. You have the right to access your medical records as allowed by law.

10. You have the right to be given information about John Deere Health Plan, its services, about the doctors providing care, and about your rights and responsibilities as an enrollee.

11. You have the right to a candid discussion with your participating provider about all appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.

12. You have the right to be given information by the Plan about our financial arrangements with participating providers, including financial incentives based on the cost of services and quality of care.

Enrollee Responsibilities

1. You are responsible to read this member handbook and other enrollee materials.

2. You are responsible for following the rules and limitations that are explained in this member handbook.

3. You are responsible for contacting only John Deere Health Plan participating providers to arrange medical care when needed.

4. You are responsible for notifying your John Deere Health Plan provider if you have to cancel or reschedule your appointment.

5. You are responsible for getting a preauthorization for referral services, when needed, as explained in your member handbook.

6. You are responsible for complying with the limits of the preauthorized referral.

7. You are responsible for carrying and using your member ID card. Always identify yourself as a John Deere Health Plan enrollee before you receive medical services.

8. You are responsible for providing information to your medical provider so that he or she can give proper care to you.

9. You are responsible for following instructions given to you by your health care provider.

One of the most important responsibilities you have is to use contracted providers.

The only exceptions to this rule are:

1) when you have received a preauthorized referral through a contracted doctor in advance to get care from a non-contracted provider.

2) in a medical emergency situation.

Remember that not all providers in your community are contracted. That's why we mailed a provider directory to you with this member handbook. Keep in mind that the directory sometimes changes. You can also call the Customer Service number listed on your member ID card to find out if a provider is contracted or order another provider directory.

It is your responsibility to keep any appointments you make with contracted providers or to call and cancel or reschedule the appointment. John Deere Health Plan will not pay for any charges for missed appointments.

CHOOSING A PRIMARY CARE PHYSICIAN

As a member of John Deere Health Plan, you must choose a contracted Primary Care Physician (PCP). You are encouraged to use your PCP for your medical care, but you may self-refer to another contracted doctor to receive medical care.

With a PCP, you won't have to navigate the health care system alone. Your PCP can help you coordinate all of your health care services, from routine physicals to referrals to specialists. With a PCP:

- You have a doctor you can call your own and who knows your medical history and personal preferences.
- You have a doctor that will work as a team with the specialists you see.
- Your health screenings are usually more regular.
- You can avoid duplication of office visits, tests, and other procedures.

You may choose your PCP from any of the contracted doctors listed in the Primary Care Physician section of the enclosed provider directory. The providers listed in this directory are not employees of the health plan; they have a contract with the health plan. Keep in mind that the directory sometimes changes, so just call the Customer Service number listed on your member ID card to find out if a certain doctor is contracted or not.

You can change your PCP anytime, and you do not need approval. All you need to do is give John Deere Health Plan 30 days' notice. You can notify John Deere Health Plan in writing or by calling the Customer Service telephone number listed on your member ID card. John Deere Health Plan will change your PCP on the first day of the month after the 30-day notice.

REFERRAL PROCESS

As a member of John Deere Health Plan, you agree to see contracted providers. If you have a medical problem that is not an emergency and cannot be treated by a contracted provider, you will need a written, preauthorized referral before you see a non-contracted provider. If you seek care from a non-contracted provider without first getting a referral, then John Deere Health Plan will not pay for that care.

These are the steps you should follow to get a referral:

Step 1

See your PCP who will make a request for a referral to John Deere Health Plan.

Step 2

A medical professional will review the referral request. If there is a contracted provider who

can help you, your referral request will probably not go through. If there are no contracted providers who can treat your medical problem, you will get a referral.

Step 3

You and your PCP will be notified in writing when your referral is approved or denied. Referrals generally take two working days to be processed. If your PCP feels care is needed quickly, the referral can be done in less time.

Step 4

If you get a referral, you may only see the provider you have been referred to and only during the time noted in the referral. Be sure to take a copy of the written referral with you.

The only time you do not need a referral to see a non-contracted provider is in the case of a medical emergency.

MEDICAL EMERGENCY

It is important that you and your family members know exactly what to do in case of a **medical emergency.** Become familiar with the emergency procedures before an emergency occurs, so you can take quick and proper action. **A medical emergency** is medical care that is needed immediately because of an injury or sudden illness. Examples of **medical emergencies** are:

- Choking
- Serious breathing problems
- Broken bones
- Loss of consciousness
- Severe or unusual bleeding
- Poisoning
- Severe burns
- Convulsions
- Severe pain

When you have a medical emergency, go to the nearest hospital emergency room. You do not need a referral when you have a medical emergency. If you are not sure you have a medical emergency, call your PCP before you get help.

Nonemergency Care

If you have a sickness or injury that does not put your health or life in danger or otherwise needs immediate care, you need **nonemergency care.** In these cases, you should call your PCP first. Do not go to the emergency room. Your PCP will help you get the best care. Examples of conditions needing **nonemergency care** are:

- Cold or flu
- Sore throat
- Earache
- Sprains
- Headache
- Minor cuts or burns
- Bruises

If you go to the emergency room for **nonemergency care,** you may have to pay a $25 copayment, due at the time of the visit.

Medical Care When You Are Away From Home

If you are away from home and have a **medical emergency,** get help right away from the nearest hospital or clinic. After you have seen a provider for the **medical emergency,** call your PCP for any follow-up care. John Deere Health Plan will pay for any **medical emergency** you have while you are away from home.

If you get **medical emergency** care while you are away from home, have the provider send bills to the address below.

John Deere Health Plan, Inc.
3800 23rd Ave., Suite 200
Moline, Illinois 61265

If you are away from home and need **nonemergency care** but cannot find a contracted provider near you, call Customer Service. The phone number is listed on your member ID card. If you do not call, then John Deere Health Plan will not pay for the service.

Emergency Ambulance

John Deere Health Pian will not pay for you to ride in an ambulance unless it is a medical emergency or a contracted provider has approved the service. If you use the ambulance for any other reason, John Deere Health Plan will not pay for the service.

John Deere Health Plan covers medically necessary ambulance services when you meet the following conditions:

- Your sickness or injury is serious enough that you can only go to the hospital in an ambulance.
- If you go in an ambulance, you must be taken to the closest hospital with the right equipment to help you.
- If you are going from one hospital to another, to a skilled nursing facility, or to a licensed nursing home.

John Deere Health Plan will not pay for the following types of services:

- Transportation from your home to your doctor's office.
- Transportation to the outpatient area of a hospital, unless a contracted provider or John Deere Health Plan decides that your sickness or injury requires it.
- Transportation from one private home to another.

YOUR BENEFITS

It is important that you know exactly what services your health plan avers. Please read your EOC for complete details on your benefits and any rules that apply.

Remember that you must use contracted providers for these services to be covered. The only exceptions are when you have a pre-authorized referral or a medical emergency. Please see the enclosed provider directory for a list of contracted providers in your area.

Accidents and Illnesses

John Deere Health Plan will pay for your medical bills if you are hurt or sick. You can get the care you need at your doctor's office, in a clinic or hospital, or in your home. When you need medical care and it is not an emergency, you must see a contracted doctor. Before you see a provider that is not contracted with John Deere Health Plan, you must first get a referral from a contracted doctor.

Preventive

Children need regular medical care to keep them healthy and help them grow up strong. Regular medical checkups can also help find health, vision, and dental problems that should be taken care of before they become serious. Children also need regular checkups and immunizations to help protect them from diseases. We have enclosed an Immunization Schedule to remind you when you need to get which immunizations.

Keeping you healthy is an important part of your health care plan. To help you stay healthy, John Deere Health Plan will pay for your routine physicals, well-child care, and immunizations when you see a contracted doctor.

Hospital

John Deere Health Plan pays for any medically necessary hospital services, even if you aren't admitted to the hospital. All hospital services must be provided by a contracted doctor or arranged or approved by a contracted doctor with a contracted provider, unless you have a medical emergency or a preauthorized referral. Your health plan will pay your hospital bill for as long as a contracted doctor keeps you in the hospital.

John Deere Health Plan will not pay for the following services:

- The service of a private nurse, unless a contracted doctor and/or John Deere Health Plan approves it.
- A private room, unless it is needed to help you get well.
- The service of the hospital barber or beauty shop.
- Telephone and television.
- Going to the hospital for dental care, unless you have a special condition that stops you from going to the dentist's office for dental care.
- Staying in the hospital for surgery or medical care that does not require a stay in the hospital.

Mental Health/Substance Abuse

We offer convenient and confidential mental health and substance abuse services through our contract with United Behavioral Health.

By calling United Behavioral Health at 1-800-867-6758 (TTY/TDD for the hearing impaired is 1-630-467-8751) between 8:00 am – 7:00 p.m., you will be connected with a contracted experienced mental health care expert. He or she will determine your needs and then link you with a mental health or substance abuse provider in your area. This is called "prior authorization." It helps you get the help you need quickly and conveniently from a contracted provider. Remember that all inpatient and outpatient mental health and substance abuse services require prior authorization by United Behavioral Health before treatment.

Mental health and substance abuse services are limited to a maximum of **30** inpatient days/visits per calendar year and a maximum of 20 outpatient days/visits per calendar year.

Outpatient Prescription Drugs

John Deere Health Plan will pay for prescription drugs when they are ordered by a contracted provider and supplied by a plan pharmacy. See the enclosed provider directory for a list of contracted pharmacies in your area. Be sure to present your member ID card to the pharmacy.

A pharmacy will not dispense more than a 30-day supply of each prescription.

Always request generics whenever they are available so you do not have to pay anything. If you get a brand name drug but an approved generic drug is available, then John Deere Health Plan will not pay for the brand name drug.

Your plan does not cover over-the-counter drugs that do not require a prescription. Your plan also excludes some types of prescription **drugs.** Some prescription drugs, too, may require prior authorization. The contracted doctor or pharmacy should contact John Deere Health Plan to pre-authorize such drugs.

Vision

If you need eye care, you must see one of our contracted Davis Vision providers (optometrist or ophthalmologist). You *can* call Davis Vision directly at 1-800-999-5431 to get a list of contracted providers in your area. This toll-free number is operational Monday through Friday 7 a.m. to **9** p.m. and Saturday 8 a.m. to 2 p.m.

John Deere Health Plan will pay for the following when provided by a contracted Davis Vision provider:

- one eye exam every 12 consecutive months.
- prescription contact lens, lenses, and/or frames up to maximum benefit of $100 once every 12 months.

Your health plan will not pay for the replacement of broken lenses or frames, unless you are eligible for new lenses or frames at the time.

Hearing

Your plan covers any medically necessary hearing services authorized or provided by a contracted provider.

Dental

Your plan covers preventive, primary, and major dental services up to a maximum of $1000 per calendar year. Preventive services – exams, X-rays, cleanings, fluoride treatments – are coveted once every six months.

Primary and major dental services must be medically necessary. Your plan does not cover orthodontics or purely cosmetic services. The only time your health plan will pay for cosmetic dental care is when it is needed because of an accidental dental injury.

There are no dentists listed in the enclosed provider directory. That is because you can see any dentist in your area, and you do not need a referral.

Additional Benefits

John Deere Health Plan will pay for the following services if they are medically necessary, authorized by a contracted doctor, and provided by a contracted provider.

- Home Health - must be approved in advance by John Deere Health Plan
- Chiropractic - with a preauthorized referral
- Hospice - must be approved in advance by John Deere Health Plan
- Nursing Facility - limited to a maximum of 100 days per calendar year
- Durable Medical Equipment
- Prosthetic Devices
- Physical/Occupational/Speech Therapy - limited to a maximum of 60 outpatient treatment days per disability
- Laboratory and X-ray
- Organ/Tissue Transplants - Contracted doctor must contact John Deere Health Plan in advance to preauthorize and plan care.

Optum® Care24

Sometimes you may need to talk about your medical condition.. .ask a question about a prescription you are taking.. .or maybe just better understand what your doctor has told you. That's why we have contracted with Optum to give you a service called Optum Care24. Optum Care24 is a toll-free phone line staffed by contracted registered nurses and professional counselors 24-hours-a-day, seven-days-a-week, 365-days-a-year. You can call anytime with your questions or concerns.

All you have to do to access this free problem-solving resource is call 1-800-867-6760 (TTY/TDD for the hearing impaired is 1-800-855-2800).

HEALTH CARE BILLS

John Deere Health Plan will pay for any medically necessary, covered services explained in this member handbook and in the EOC; you must see a contracted provider for these services (unless you have a medical emergency or a preauthorized referral). If you get a medical bill, please call your local Customer Service Department. You do not have to pay anything for covered services provided by a contracted provider. You may have to pay a $25 copayment, however, if you go to the emergency room but do not have a medical emergency.

SERVICES NOT COVERED BY JOHN DEERE HEALTH PLAN

It is important that you know what things are not covered by your health care plan. Please read your EOC for complete details on what services your health plan does not cover (called "exclusions"). The services that John Deere Health Plan does not cover include, but are not limited to, the following:

- Any service provided by a non-contracted provider, unless you have a medical emergency or a pre-authorized referral.
- Custodial services.
- Services for convenience, comfort, appearance, educational, recreational, or vocational reasons
- Cosmetic surgery needed only to help you look better. (Your health plan will pay for reconstructive surgery, however, if it is needed to correct a defect caused by a prior surgery. Your health plan will also pay for reconstructive surgery if it is needed because you were born with a disease or anomaly that resulted in a functional defect.)
- Any drugs, services, or supplies that are experimental or investigational.
- Biofeedback treatment; holistic medicine; acupuncture.; hypnotherapy; sleep therapy; behavior training, conduct disorders and related family counseling; remedial education and treatment of learning disabilities.
- Weight loss clinics or programs unless it is part of a plan-approved wellness program. Surgery for being overweight is not covered unless John Deere Health Plan approves it. You must see a contracted doctor and receive prior approval from John Deere Health Plan for these surgeries.

MEMBER COMPLAINT AND GRIEVANCE PROCEDURES

Complaint Procedure

If you have a complaint about the service or care you get from John Deere Health Plan or its contracted providers, first call your local John Deere Health Plan office to talk to a customer service representative. If the representative and/or the contracted provider cannot solve your problem on an informal basis, then you have the right to file a complaint.

You can request an Enrollee Complaint Form by writing or calling your local John Deere Health Plan office. You must fill out, sign, and return the Enrollee Complaint Form to John Deere Health Plan within 90 days from the date the problem occurred. You can send the form to:

John Deere Health Plan, Inc.
Customer Service, Appeal Department
3800 23rd Avenue, Suite 200
Moline, Il 61265

Within 14 days of getting the complaint, John Deere Health Plan will mail a written decision to you and anyone else that is involved.

Expedited Procedure

If waiting the standard 14 days for a decision may put your life, health, or maximum recovery at risk, John Deere Health Plan will expedite its decision process. In such cases, John Deere Health Plan will issue its decision within 72 hours of receiving your complaint.

Grievance Procedure

If you are still not happy with the decision, you have the right to file a formal appeal to the John Deere Health Plan Enrollee Grievance Committee. This appeal must be filed within 14 days from the date that John Deere Health Plan sent you the decision. John Deere Health Plan will send you written acknowledgement that they received your appeal within 10 days of receiving it.

Your appeal will be heard at an Enrollee Grievance Committee meeting. John Deere Health Plan will tell you when and where the meeting will be held. You will also get copies of the information the committee has about your case. You or the person who is representing you have the right to *go* before the Enrollee Grievance Committee and present your case. After hearing all of the information, the Enrollee Grievance Committee will let everyone involved know its final decision.

Appeal to the State *of* Iowa Insurance Commissioner

If you **go** through the John Deere Health Plan complaint and grievance processes but are still unhappy with the decision, you can ask for a review by the State of Iowa Insurance Commissioner, You must write to the address below no later than 30 days after the final decision by John Deere Health Plan.

Iowa Insurance Division
Lucas State Office **Building**
Des Moines, Iowa **50319**

THIRD PARTY LIABILITY

If you are hurt in an accident, and another person or organization is legally responsible, you may demand that the person or organization repay you for your costs. In these cases, John Deere Health Plan may have paid for medical care that could be the responsibility of that person or organization. John Deere Health Plan has the right to be repaid for your medical care.

As a member you agree:

1. To help John Deere Health Plan get information about the accident and how it happened.
2. To let John Deere Health Plan know if you, or someone who represents you, asks to be repaid for any costs due to the accident. This is called making a claim.
3. To include the amount of the benefits John Deere Health Plan paid for treatment for your injuries in any claims you make.
4. To give John Deere Health Plan a lien equal to the value of the medical care John Deere Health Plan gave you. (When you give someone a lien, you give them the legal right to your property until a debt is repaid.) This lien may be filed with the person or organization who caused your injuries, his or her representative, or a court that can rule on the matter.
5. To repay John Deere Health Plan, if you receive payment from another party, for your medical costs due to the accident. This repayment should come from any payment made to you by the person or organization that caused your accident.
6. To let John Deere Health Plan file a lawsuit against the person who caused your accident, for the cost of your medical care.
7. That you will pay John Deere Health Plan for its efforts - and for attorney fees - to get you to pay the company for medical costs you owe.

If the person or organization who caused your accident is going to repay you, John Deere Health Plan will be repaid first. You will get any money that is left.

NONDISCRIMINATION POLICY

John Deere Health Plan members have the right to receive services from the HMO without discrimination due to age, sex, color, race, religion or national origin. We encourage any member who feels unfair discrimination has occurred to file a complaint in accordance with the John Deere Health Plan complaint/grievance procedure. We are committed to making sure our members are treated fairly.

CUSTOMER SERVICE

We are here to help you. If you have questions or problems or need help getting care, just call **us.** See below for the number of your local Customer Service Department. For faster service, please have your member ID card ready when you call.

We want to give you the best service possible. You can **help by doing these things:**

Let the HAWK-I Program know if:

- You change your address.
- You obtain other health insurance.

Let your local John Deere Health Plan office know if:

- You change your Primary Care Physician (PCP).
- You receive money from a lawsuit, insurance or for worker's compensation.
- You see a doctor because you have been hurt in an accident.
- You have another company or person helping pay for your medical bills.

CUSTOMER SERVICE HOURS

Monday-Thursday *7* a.m. - 6 p.m.
Friday *7* a.m. - *5* p.m.
Saturday 8 a.m. - Noon

CUSTOMER SERVICE NUMBERS

TTY/TDD **(for** the hearing impaired):
1-800-884-4327.

Cedar Rapids
1845 51st Street NE
Cedar Rapids, IA *52402*
319-378-5200 or 1-800-373-9811

Des Moines
4201 Westown Parkway, Suite *325*
West Des Moines, IA *50266-6720*
515-223-0307 or 1-800-373-5050

Dubuque
1660 Embassy West Drive, Suite 150
Dubuque, LA *52002*
319-588-2831 or 1-800-224-6597

Quad Cities
3740 Utica Ridge Road
Bettendorf, IA *52722-1638*
319-344-4522 or 1-800-747-1446

Waterloo
3022 Airport Boulevard
P.O. Box 9000
Waterloo, LA *50704*
319-291-6130 or 1-800-224-6596

JOHN **DEERE**
HEALTH

John Deere Health Plan, Inc.
A Health Maintenance Organization

1300 River Drive, Suite 200 • Moline, IL 61265
www.johndeerehealth.com

Questions? Call toll-free 1-800-247-9110
(TTY/TDD hearing impaired 1-800-884-4327)

Si desea una traducción al Español de este folleto,
o si tiene preguntas sobre John Deere Health Plan,
llame gratuitamente al 1-800-247-9110.

ASSURANCE OF NON-DISCRIMINATION

No person on the grounds of race, color, national origin, sex, age, or disability shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or service provided by John Deere Health Plan. Inc.

Medical providers are independent contractors. not employees or agents of the health plan. Our members and their medical providers, not the health plan, decide what medical care they receive and how they receive it. John Deere Health only determines what medical care will be paid for under their benefit plan.

2/00

Deloitte & Touche LLP

Member of ABC Consulting

ACTUARIAL REPORT

IOWA HAWK-I CHILDREN'S HEALTH INSURANCE PROGRAM

JOHN DEERE HEALTH CARE PLAN

JANUARY 26,1999

Deloitte Touche Tohmatsu

Actuarial Report
Iowa Hawk-I Children's Health Insurance Program
November 1998

Background

This actuarial report was developed at the request of the Health Care Finance Administration by Deloitte & Touche, an independent consulting firm. The purpose of the report is to supplement the Iowa Department of Human Services' application for Federal funds under Title XXI of the Social Security Act for the Children's Health Insurance Program.

Title XXI, Section 2103, specifies that the scope of health insurance coverage under this program must consist of either benchmark coverage, benchmark-equivalent coverage, existing comprehensive state-based coverage, or Secretary-approved coverage. Certain actuarial values must be set forth in an actuarial opinion in an actuarial report to accompany the State's application. Those actuarial values include the following:

- The actuarial value of the coverage provided by the benchmark benefit packages;
- The actuarial value of the coverage offered under the State child health plan;
- The actuarial value **of** the coverage of any categories of additional services under benchmark benefit packages; and
- The actuarial value of any categories of additional services under coverage offered by the State child health plan.

This actuarial report includes the actuarial values listed above, along with supporting documentation and other information.

Benchmark Benefit Package

A benchmark benefit package as specified by Title XXI, Section 2103, is as follows:

State employee coverage provided by Principal Health Care of Iowa Primary Care. Principal Health Care of Iowa Primary Care (Principal Health) is **an** HMO coverage option available to Iowa State employees. Principal Health provides comprehensive coverage for hospital, surgical, physician, and other services. It is one of several plans offered to Iowa state employees in a multiple choice setting which includes indemnity plans, PPOs, point of service plans and other HMOs. Principal Health was chosen as a benchmark due to its comprehensive benefit coverage and its large enrollment level of state employees. The benefit design of Principal Health is similar to a typical HMO, with an emphasis on preventive care and a primary care physician channeling mechanism.

Children's Health Insurance Program Benefit Package

House File 2517, Section 6.8(e)(1-14) describes the benefits to be included in the Hawk-I program, as adopted by the Hawk-I board in consultation with the Iowa Department of Human Services. These include:

- Inpatient hospital services, including Medical, Surgical, ICU, Mental Health and Substance Abuse (MWSA) services.
- Nursing care services including Skilled Nursing Facility (SNF) services.
- Outpatient hospital services including **ER,** surgery, laboratory, radiology and other services.
- Physician services, including:
  - Surgical
  - Medical
  - Office Visits
  - Newborn, well baby and well child care
  - Immunizations
  - Urgent care
  - Specialist care
  - Allergy testing and treatment
  - MWSA visits
- Ambulance services
- Physical therapy
- Speech therapy
- Durable Medical Equipment (DME)
- Home Health care
- Hospice services
- Prescription drugs
- Dental services including preventative services
- Hearing services as medically necessary
- Vision services including corrective lenses

Cost sharing provisions are addressed by reference to the CHIP benchmark plan requirements of the Balanced Budget Act of 1997, and Section 11 of House File 2517. Cost sharing (premiums or copayments) for children with family incomes between 150% and 185% of FPL will not exceed 5% of annual family adjusted gross income. Final cost sharing provisions were not available at the time this report was prepared. Exhibit 2 lists a plan design grid for John Deere Health Care. We developed CHIP premium rates for John Deere Health Care based on the cost sharing provisions and benefit limitations as shown in Exhibit 2. Exhibit **3** shows a plan design

grid for Principal Health. Actuarial values for Principal Health are based on the cost sharing and benefit limitations as shown in Exhibit **3.**

Methodology for Determining Actuarial Equivalency

In order to determine the actuarial equivalency of John Deere Health Care to the benchmark plan Principal Health, the following methodology was used.

(1) Identification of a standardized set of utilization and price factors

The standardized set of utilization and price factors used to determine the actuarial equivalency of John Deere Health Care to Principal Health is set forth in Exhibit **1** of this report.

Due to the lack of insured experience data on this uninsured population, we had to develop estimates of health care utilization which we felt were appropriate for this population. Factors which we considered included:

- Age distribution of the projected HAWK-I population;
- Benefit design;
- **A** moderate level of managed care utilization management;
- Experience from commercial HMO populations; and
- Experience from other state programs for similar populations.

The utilization assumptions selected are one set of assumptions from a reasonable range of possible assumptions. Actual utilization is likely to differ, which will affect program costs.

The utilization is expressed as the number of services per 1000 eligibles per year. The service units are the number of hospital days, surgeries, office visits, tests, or prescriptions, etc.

The cost per service assumptions reflect the assumed intensity of services provided and the following reimbursement assumptions:

- Hospital inpatient reimbursement at estimated commercial managed care reimbursement rates for a population similar to the HAWK-I Program.
- Hospital outpatient reimbursement based upon the inpatient reimbursement, and reflective of normative relationships between inpatient and outpatient costs.
- Physician services at 100% of RBRVS reimbursement levels for Iowa. Costs are based on 1998 RBRVS plus 3% estimated trend to 1999.
- Other costs at normative levels based upon information from the Deloitte & Touche database.

(2) Calculation of the actuarial value of the benchmark plan (Principal Health) and the categories of additional services included in the benchmark plan

Based on the standardized set of utilization and cost factors described above with the applicable cost sharing and benefit limitation provisions from Exhibit **3,** the aggregate actuarial value and the actuarial value of categories of additional services provided by the benchmark plan were determined. The actuarial values, stated in terms of average monthly per member per month costs, are as follows:

Aggregate Actuarial Value	**$44.33**
Additional Services Actuarial Value	
Prescription Drugs	$7.00
Mental Health Services	**$1.36**
Vision Services	**$1.15**
Hearing, Services	N/A*

A more detailed pricing summary for Principal Health is shown in Exhibit 5.

* We did not explicitly value hearing services as a distinct pricing category. It is **part** of miscellaneous physician services.

(3) Calculation of the actuarial value of John Deere Health Care and the categories of additional services included in John Deere Health Care

Based on the standardized set of utilization and cost factors described in Exhibit 1, along **with** the cost sharing and benefit limitation provisions from Exhibit **2,** the aggregate actuarial value and the actuarial value of categories of additional services provided by John Deere Health Care were determined. The actuarial values, stated in terms of average monthly per member costs, are as follows:

Aggregate Actuarial Value	**$61.12**
Additional Services Actuarial Value	
Prescription Drugs	**$8.40**
Mental Health Services	**$1.34**
Vision Services	**$1.92**
Hearing Services	N/A*

A more detailed pricing summary for John Deere Health Care is shown in Exhibit 4.

* We did not explicitly value hearing services as a distinct pricing category. It is **part** of miscellaneous physician services.

(4) Determination of actuarial equivalence of John Deere Health Care to the benchmark plan (Principal Health)

The proposed CHIP program package offered by John Deere Health Care has an aggregate actuarial value that is at least actuarially equivalent to that of the benchmark plan Principal Health.

With respect to each of the categories of additional services described in Section 2 103. the proposed benefit packages through Iowa Health Solutions have an actuarial value that is at least 75% of the actuarial value of the coverage of that category of services in the benchmark package. **A** summary table is shown below.

	Iowa Health Solutions	**Principal Health**
Aggregate Actuarial Value	$61.12	**$44.33**
Additional Services Actuarial Value		
Prescription Drugs	$8.40	$7.00
Mental Health Services	$1.34	$1.36
Vision Services	$1.92	$1.15
Hearing Services	N/A*	N/A*

* We did not explicitly value hearing services as a distinct pricing category. It is part of miscellaneous physician services.

I. Timothy **h4.** Ross, am associated with the firm of Deloitte & Touche, and have been retained by the Iowa Department of Human Services to evaluate the proposed Hawk-I plans in comparison to a benchmark plan, as required by Title XXI of the Social Security Act. I am a member of American Academy of Actuaries and meet the qualification standards for an opinion of this type.

Based on my review and comparison of the proposed John Deere Health Care Hawk-I plan and the benchmark plan, it is my opinion that:

- The Hawk-I plan meets or exceeds all required comparisons to the benchmark plan;
- The report has been prepared using generally accepted actuarial principles and methodologies;
- The report has been prepared in accordance with the principles and standards of the Actuarial Standards Board for such reports;
- **A** standardized set of utilization and price factors has been used;
- The same principles and factors have been applied in comparing the values of different coverages (or categories of service);
- Differences in coverage based on the method of delivery of means of cost control or utilization used have not been taken into account.

This report and opinion has been prepared to comply with the requirements of Titles XXI, and for no other purpose. Insurers, managed care providers, or other providers may not rely on this information in forming a decision to participate, or not to participate, in the HAWK-I Program.

Timothy M. Ross, **ASA,** MAAA
Senior Manager
Deloitte & Touche

Exhibit 1
Iowa HAWK-I Program
Standardized Utilization and Price Factors

Service Category	Utilization (per 1,000 members annually)	Unit Price
HOSPITAL INPATIENT		
MED/SURG/ICU	72	$1,000
MENT HLTH	13	$450
SUB ABUSE	10	$400
MATERNITY		$1,050
SNF		5300
SUBTOTAL	95	S861
HOSPITAL OTHER		
O.P. SURGERY	26	$850
EMERGENCY ROOM	204	$180
OTHER	61	$250
SUBTOTAL	291	$254
PHYSICIAN SERVICES		
SURGERY - I.P.	20	5706
SURGERY - OTHER	77	$90
ANESTHESIA	46	$93
OBSTETRICS		$691
INPATIENT VISIT	71	$62
OFFICE VISITS	2,244	$41
WELL CHILD	612	S71
CONSULTS	87	$104
EMERGENCY ROOM	230	565
MH VISITS	204	$80
SA VISITS	102	$80
LAB	1,632	$12
RADIOLOGY	439	$90
PHYSICAL MEDICINE	92	518
IMM. & INJ.	791	$9
REFRACTIONS	306	$45
MISC	459	557
SUBTOTAL	7,412	543
DENTAL SERVICES		
DIAGNOSTIC	2,800	$21
PREVENTIVE DENTAL	1,500	$17
RESTORATVE	650	$74
ORAL SURGERY	160	$65
PERIODONTICS	50	$77
PROSTHETICS	80	$214
ENDODONTICS	20	5264
ORTHODONTIA	15	$3,000
SUBTOTAL	5,275	$35
OTHER SERVICES		
PRESCRIPTION DRUGS	4,000	$28
CORRECTIVE LENSES	102	$90
HOME HEALTH	10	$265
AMBULANCE	8	$215
DME	71	*$52*
SUBTOTAL	4,191	$31

Exhibit 2
John Deere Health Care
Summary *of* Plan Provisions

Hospital Facility Services	100% of allowed charges for inpatient, outpatient, and maternity charges. There is a $25 emergency room copayment (waived if admitted).
Physician Services	100% of allowed charges for: **(1)** Office visits/home visits/skilled nursing facility **visits** (2) Hospital visits **(3)** Surgical procedures **(4)** Allergy testing and injections (5) Routine physicals, well child care and immunizations Maternity and newborn baby care are not covered
Mental Health and Substance Abuse Services	**(1)** Inpatient Facility: 100% of allowed charges. Maximum of 15 inpatient days per calendar year. (2) Outpatient Facility: 100% of allowed charges. Maximum of 30 outpatient days per calendar year. **(3)** Inpatient Physician: 100% of allowed charges. Maximum of 15 inpatient visits per calendar year. **(4)** Outpatient Physician: 100% of allowed charges. Maximum of **30** outpatient visits per calendar year. (5) Office: 100% of allowed charges. Maximum of 20 office visits per calendar year.
Emergency Ambulance	100% **of** allowed charges in an emergency
Home Health Care & Hospice Care	100% of allowed charges. Must be approved by John Deere Health Care
Skilled Nursing Facility	100% of allowed charges. Maximum of 100 days per calendar year.
Durable Medical Equipment	100% of allowed charges
Physical/Occupational/Speech Therapy	100% of allowed charges. Maximum of 60 outpatient treatment days per disability
Laboratory and X-Ray Services	100% of allowed charges
Prescription Drugs	100% for all prescribed drugs covered under the **John** Deere Health Care formulary. Maximum benefit of $1,000 per calendar year.

Exhibit 2
John Deere Health Care
Summary of Plan Provisions

Dental	(1) Preventive Services: 100% for exams, x-rays and cleanings, fluoride treatments, and sealants. Coverage is limited to once every six months. (2) Primary Services: 100% for fillings, root canals, periodontics, oral surgery, crowns, dentures and bridge work. Orthodontia is not covered. Overall calendar year maximum of $500.
Vision Services	(1) Lens of Lenses: Single Vision (one pair): $37.00 (2) Frames: $30.00 (3) Examinations: Optometrist: $45.00 Ophthalmologist: $50.00 Two lenses, one frame, and one exam are covered once every 12 consecutive months.

Exhibit 3
Principal Health Care of Iowa Primary Care
Summary of Plan Provisions

Plan Provisions	Principal Health Care of Iowa Primary Care
Deductible Single/Family	None
Coinsurance Percentage	Varies; see below
Out of Pocket limit Single/Family	$750/$1,500 or 200% of annual premium, whichever is less, per contract year. All copayments and coinsurance go toward out-of-pocket limit.
Hospital Services	
Room & Board	100% if authorized. Semi-private basis, unless medically necessary to use private room.
Medical/Surgical/ICU	100%.
Skilled Nursing Facility	100% if authorized. Maximum 62 days per 12 month period.
Outpatient Surgery	100%.
Emergency Room	$50 copay or 50% of total bill, whichever is less, for ER visits to plan hospitals. $50 copay or 50% of total bill, whichever is less, for ER visits to out-of-area providers. In-area copayment waived if admitted within 24 hours.
Inpatient Mental Health/Substance Abuse	**80%.** Maximum 30 days per member per 12 month period.
Outpatient Mental Health/Substance Abuse	**$15** copay per visit. Maximum **30** individual or 45 group visits per member per 12 month period.
Physician Services	
Surgery	100%
Inpatient Visits	100%
Office Visits	***$5*** copay per visit for primary care physician. $10 copay per visit for referral specialty care physician.
Preventive Care	$5 copay per visit for routine physicals. $5 copay per visit for well child care (primary care physician)
Emergency Room	$5 copay for primary care physician office ER visits.
Mental Health/Substance Abuse Visits	100%. Maximum **30** days per member per 12 month period for inpatient physician care.
X-Ray & Lab	100%
Immunizations and Injections	$5 copay when provided by a primary care physician. $10 copay for allergy treatment when provided by referral specialty physician.
Vision/Hearing Exams	100% for optometrist and $10 copay for ophthalmologist. Limit one exam per 12 months. $5 copay per visit for hearing exams.

Exhibit 3
Principal Health Care of Iowa Primary Care
Summary of Plan Provisions (cont'd)

Plan Provisions	Principal Health Care of Iowa Primary Care
Physical, Speech, Occupational and Respiratory Therapy	**$10** copay per visit. Maximum treatment period of 62 consecutive calendar days per condition.
Chiropractor	$10 copay per visit with approved referral.
Additional Services	
Prescription Drugs	**$5** copay or **25%** per prescription, whichever is higher, **from** plan pharmacies.
Durable Medical Equipment	80% if authorized by primary care physician. 100% if provided in lieu of hospital confinement.
Prosthetic Devices	80% if authorized by primary care physician.
Eyeglasses	Not covered except 20% copayment for first pair of glasses or contact lenses after cataract surgery provided under direction of primary care physician.
Ambulance	100% to nearest facility
Home Health Care	100% if authorized with referral
Dental	80% if authorized for accidental care only. Services must be provided within 6 months of the injury.

Exhibit 4
HAWK-I Program
John Deere Family Health Plan

SERVICE CATEGORY	Baseline Utilization	Baseline Cost/Service	Breadth of Coverage	Coverage Limits	Copy	PMPM Costs Before Limits	PMPM Costs Before Copays	PMPM Costs After Copays
HOSPITAL INPATIENT								
MED/SURG/ICU	72	$ 1,000	1.00	1.00	$ -	$ 6.00	$ 6.00	$ 6.00
MENT HLTH	13	450	1.00	0.80	$ -	$ 0.49	$ 0.39	$ 0.39
SUB ABUSE	10	400	1.00	0.80	$ -	$ 0.33	$ 0.27	$ 0.27
MATERNITY		1,050		1.00	$ -	$ -	$ -	$
SNF		300		1.00	$ -	$ -	$ -	$
SUBTOTAL	95	$ 861				$ 6.82	$ 6.66	$ 6.66
HOSPITAL OTHER								
O.P. SURGERY	26	850	1.00	1.00	$ -	$ 1.84	$ 1.84	$ 1.84
EMERGENCY ROOM	204	180	1.00	1.00	$ 25	$ 3.06	$ 3.06	$ 2.64
OTHER	61	250	1.00	1.00	$ -	$ 1.27	$ 1.27	$ 1.27
SUBTOTAL	291	$ 254				$ 6.17	$ 6.17	$ 5.75
PHYSICIAN SVCS								
SURGERY - I.P.	20	706	1.00	1.00	$ -	$ 1.18	$ 1.18	$ 1.18
SURGERY - OTHER	77	90	1.00	1.00	$ -	$ 0.58	$ 0.58	$ 0.58
ANESTHESIA	46	93	1.00	1.00	$ -	$ 0.36	$ 0.36	$ 0.36
OBSTETRICS		691		1.00	$ -	$ -	$ -	$
INPATIENT VISIT	71	62	1.00	1.00	$ -	$ 0.37	$ 0.37	$ 0.37
OFFICE VISITS	2,244	41	1.00	1.00	$ -	$ 7.67	$ 1.61	$ 7.67
WELL CHILD	612	71	1.00	1.00	$ -	$ 3.62	$ 3.62	$ 3.62
CONSULTS	87	104	1.00	1.00	$ -	$ 0.75	$ 0.75	$ 0.75
EMERGENCY ROOM	230	65	1.00	1.00	$ -	$ 1.25	$ 1.25	$ 1.25
MH VISITS	204	80	1.00	0.70	$ -	$ 1.36	$ 0.95	$ 0.95
SA VISITS	102	80	1.00	0.70	$ -	$ 0.68	$ 0.48	$ 0.48
LAB	1,632	12	1.00	1.00	$ -	$ 1.63	$ 1.63	$ 1.63
RADIOLOGY	439	90	1.00	1.00	$ -	$ 3.29	$ 3.29	$ 3.29
PHYSICAL MEDICINE	92	18	1.00	1.00	$ -	$ 0.14	$ 0.14	$ 0.14
IMM. & INJ.	791	9	1.00	1.00	$ -	$ 0.59	$ 0.59	$ 0.59
REFRACTIONS	306	45	1.00	1.00	$ -	$ 1.15	$ 1.15	$ 1.15
MISC	459	57	1.00	1.00	$ -	$ 2.18	$ 2.18	$ 2.18
SUBTOTAL	7.412	$ 43				$ 26.80	$ 26.19	$ 26.19
DENTAL SERVICES								
DIAGNOSTIC	2,800	21	1.00	0.90	$ -	$ 4.90	$ 4.41	$ 4.41
PREVENTIVE DENTAL	1,500	17	1.00	0.90	$ -	$ 2.13	$ 1.91	$ 1.91
RESTORATVE	650	74	1.00	0.90	$ -	$ 4.01	$ 3.61	$ 3.61
ORAL SURGERY	160	65	1.00	0.90	$ -	$ 0.87	$ 0.78	$ 0.71
PERIODONTICS	50	77	1.00	0.90	$ -	$ 0.32	$ 0.29	$ 0.25
PROSTHETICS	80	214	1.00	0.90	$ -	$ 1.43	$ 1.28	$ 1.28
ENDODONTICS	20	264	1.00	0.90	$ -	$ 0.44	$ 0.40	$ 0.40
ORTHODONTIA	15	3,000		-	$ -	$ -	$ -	$
SUBTOTAL	5,275	$ 32				$ 14.10	$ 12.68	$ 12.68
OTHER SERVICES								
PRESCRIPTION DRUGS	4,000	28	1.00	0.90	$ -	$ 9.33	$ 8.40	$ 8.40
CORRECTIVE LENSES	102	90	1.00	1.00	$ -	$ 0.77	$ 0.77	$ 0.77
HOME HEALTH	10	265	1.00	1.00	$ -	$ 0.22	$ 0.22	$ 0.22
AMBULANCE	8	215	1.00	1.00	$ -	$ 0.14	$ 0.14	$ 0.1
DME	71	52	1.00	1.00	$ -	$ 0.31	$ 0.31	$ 0.3
SUBTOTAL	4,191	$ 31				$ 10.77	$ 9.84	$ 9.8
BASELINE MEDICAL COSTS						$ 64.66	$ 61.54	$ 61.1
INDUCED DEMAND						$ 3.00	$ 3.00	$ 1.5
TOTAL MEDICAL COSTS						$ 67.66	$ 64.54	$ 62.6

Exhibit 5

Principa

SERVICE CATEGORY	Baseline Utilization	Cost/Service	Breakage	Coverage	copay	Before Limits	PMPM Costs Before Copays	After Copays
HOSPITAL INPATIENT								
MED/SURG/ICU	72	$ 1,000	1.00	1.00	$ -	$ 6.00	$ 6.00	$ 6.00
MENT HLTH	13	450	1.00	0.90	$ 68	$ 0.49	$ 0.44	$ 0.37
SUB ABUSE	10	400	1.00	0.90	$ 60	$ 0.33	$ 0.30	$ 0.26
MATERNITY		1,050		1.00	$ -	$ -	$ -	$
SNF		300		1.00	$ -	$ -	$ -	$
SUBTOTAL	95	$ 861				$ 6.82	$ 6.74	$ 6.63
HOSPITAL OTHER								
O.P. SURGERY	26	850						
EMERGENCY ROOM	204	180	1.00	1.00	$ -50	$ 1.84	$ 1.84	$ 1.84
OTHER	61	250	1.00	1.00	$ -	$ 1.27	$ 1.27	$ 1.27
SUBTOTAL	291	$ 254				$ 6.17	$ 6.17	$ 5.32
PHYSICIAN SVCS								
SURGERY - I.P.	20	706	1.00	1.00	$ -	$ 1.18	$ 1.18	$ 1.18
SURGERY - OTHER	77	90	1.00	1.00	$ -	$ 0.58	$ 0.58	$ 0.58
ANESTHESIA	46	93	1.00	1.00	$ -	$ 0.36	$ 0.36	$ 0.36
OBSTETRICS		691		1.00	$ -	$ -	$ -	$
INPATIENT VISIT	71	62	1.00	1.00	$ -	$ 0.37	$ 0.37	$ 0
OFFICE VISITS	2.244	41	1.00	1.00	$ 5	$ 7.67	$ 7.67	$ 6
WELL CHILD	612	71	1.00	1.00	$ 5	$ 3.62	$ 3.62	$ 3
CONSULTS	87	104	1.00	1.00	$ -	$ 0.75	$ 0.75	$ 0
EMERGENCY ROOM	230	65						1.
IH VISITS	204	80	1.00	0.90	$ -15	$ 1.26	$ 1.25	$ 1.
4 VISITS	102	80					1.22	0.
AB	1,632	12	1.00	0.90	$ 15	$ 0.68	$ 0.61	$ 0.
ADIOLOGY	439	90	1.00	1.00	$ -	$ 3.29	$ 3.29	$ 3.
HYSICAL MEDICINE	92	18	1.00	1.00	$ 2.50	$ 0.14	$ 0.14	$ 0.
IM. & MJ.	791	9	1.00	1.00	$ 5	$ 0.59	$ 0.59	$ 0.
FRACTIONS	306	45	1.00	1.00	$ -	$ 1.15	$ 1.15	$ 1.
ISC	459	57						
SUBTOTAL	7.412	$ 43	1.00	1.00	$ -	$ 28.80	$ 26.59	$ 24.
DENTAL SERVICES								
DIAGNOSTIC	2.800	21		-	$ -	$ -	$ -	$
PREVENTIVE DENTAL	1.500	17		-	$ -	$ -	$ -	$
RESTORATVE	650	74		-	$ -	$ -	$ -	$
ORAL SURGERY	160	65		-	$ -	$ -	$ -	$
PERIODONTICS	50	77		-	$ -	$ -	$ -	$
PROSTHETICS	80	214		-	$ -	$ -	$ -	$
	20	264		-	$ -	$ -	$ -	$
ONTIA	15	3,000		-	$ -	$ -	$ -	$
						$ -	$ -	$
TOTAL	5,275	$				$ -	$ -	$
R SERVICES								
SCRIPTION DRUGS	4,000	28	1.00	1.00	$ 7	$ 9.33	$ 9.33	$ 7.00
CORRECTIVE LENSES	102	90		-	$ -	$ -	$ -	$
HOME HEALTH	10	265	1.00	1.00	$ -	$ 0.22	$ 0.22	$ 0.22
AMBULANCE	8	215	1.00	1.00	$ -	$ 0.14	$ 0.14	$ 0.14
)ME	71	52						
UBTOTAL	4.191	$ 29	1.00	1.00	$ -	$ 10.00	$ 9.71	$ 7.67
SELINE MEDICAL COSTS						$	$	
INDUCED DEMAND						$ 49.79	$ 49.50	$ 44.33
TOTAL MEDICAL COSTS						$ 3.00	$ 3.00	$ 1.50
						$ 52.79	$ 52.50	$ 45.83

HAWK-I

Health Plan Coverage Areas